

**STATE OF IDAHO**  
**Contract Amendment**

**CONTRACT NO.:** RC070800

**CONTRACT AMENDMENT NO.:** 3

**CONTRACTOR'S FEDERAL I.D.NO.:** 94264909700

**RFP NO.:** RRFP1103 / RFP02482

**CONTRACT PURCHASE ORDER NO.:** CPO02571

**CFDA NUMBER AND TITLE:**

**DUNS NUMBER:**

This Contract Amendment is entered into by the State of Idaho, Department of Health and Welfare, hereinafter referred to as the **DEPARTMENT**, and **UNITED BEHAVIORAL HEALTH**, hereinafter referred to as the **CONTRACTOR**. The effective date of the original contract was **04/24/2013**. The expiration date of the contract as amended is **06/30/2017**.

**ADDITIONAL SERVICES/PROVISIONS/DELIVERABLES:**

Extend contract, add funds and amend documents referenced below.

The following amended Attachments are hereby incorporated and made a part of this Agreement:

Scope of Work

Cost/Billing Procedure

Attachment 3 Definitions (from RFP)

**AMENDMENT AMOUNT** \$186,268,768.88

**SUB OBJECT** 704100-MEDICAID

**PROGRAM COST ACCOUNT (PCA)** 100% 42830 - MEDICAID PREPAID HEALTH PLANS

**CONTRACT MONITOR:** David Welsh

**CONTRACT MANAGER:** Tiffany Kinzler

THIS AGREEMENT is an amendment of the original contract between the Contractor and the Department.

WHEREAS, in order for the Department to further gather and evaluate data regarding behavioral health services and usage in Idaho, the Contractor and the Department desire to extend the contract effective period through June 30, 2017; and

WHEREAS, the Contractor and the Department desire to further amend the contract as set forth in this amendment to reflect changes in the Scope of Work, Cost/Billing Procedure, and Definitions sections; and

WHEREAS, the Department is legally authorized to enter into this agreement by power granted by Title 56, Chapter 10, of the Idaho Code; and

WHEREAS, the Contractor has been determined qualified and available to continue the provision of services for the time period covered by this Agreement; and

NOW THEREFORE, in consideration of the above recitals and the mutual covenants set forth herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Contractor and the Department do hereby agree as follows:

The parties hereby agree that all other provisions of the original contract, with the exception of the amendments as provided herein, shall remain in force during the period covered by this Agreement.

IN WITNESS WHEREOF, the Department and the Contractor have executed this Agreement.

CONTRACTOR:

United Behavioral Health  
Name of Organization

Joel R. Costa  
Name of Signature Authority (printed)

Director and Chief Financial Officer  
Title

[Signature]  
Signature

3-17-2016  
Date

Mailing Address:

11000 Optum Circle  
Eden Prairie, MN 55344

\_\_\_\_\_  
Telephone No.

Contract Number: RC070800

STATE OF IDAHO:

Department of Health and Welfare  
Name of Organization

Richard M. Armstrong, Department of Health and Welfare  
Name of Signature Authority (printed)

Director  
Title

[Signature]  
Signature

3-22-16  
Date

Mailing Address:

P.O. Box 83720  
Boise, ID 83720-0036

\_\_\_\_\_  
Telephone No.

Division of Purchasing  
Name of Signature Authority

PURCHASING OFFICER  
Title  
[Signature]  
Signature

03/23/2016  
Date

Mailing Address:

650 W. State St. Rm B-15  
Boise, ID 83702

\_\_\_\_\_  
Telephone No.

## Scope of Work

### I. General Requirements

#### A. Idaho Department of Health and Welfare (IDHW) Responsibilities: The IDHW will:

1. Provide an IDHW Contract Manager for ongoing contract administration and contract performance monitoring.
2. Designate an IDHW Contract Manager who shall have overall responsibility for the management of all aspects of this contract and the IDHW Contract Manager shall be a member of the implementation team. This person shall oversee the Contractor's progress, facilitate issue resolution, coordinate the review of deliverables, and manage the delivery of IDHW resources to the project, consulting with the Contractor as needed. The IDHW Contract Manager may designate other IDHW staff to assume designated portions of the IDHW Contract Manager's responsibility. The IDHW Contract Manager shall be the central point of communications and any deliverables to the IDHW shall be delivered to the IDHW Contract Manager and any communication or approval from the IDHW shall be communicated to the Contractor through the IDHW Contract Manager. Should disagreements arise between Contractor staff and the IDHW's Project Team, those disagreements shall be escalated for resolution through each organization's respective reporting structure. Should those disputes remain unresolved after that process, the IDHW's Contract Manager has the authority to escalate through the Division of Medicaid's leadership to the IDHW's Director who retains ultimate authority to decide the outstanding issue or question.
3. Review any required informational materials regarding the Idaho Behavioral Health Plan program prior to release, including, but not limited to brochures, provider and Member templates for correspondence. The IDHW will review draft documents, identify revisions, and return written comments to the Contractor within agreed upon timeframes.
4. Prior to the provision of services under the contract, the IDHW's Division of Medicaid will notify all current eligible Members, and mental health and substance use disorder providers enrolled under the IDHW's current network of the following:
  - a. Creation of the Idaho Behavioral Health Plan
  - b. An explanation of how the new managed care plan works; and
  - c. The Contractor's information: toll-free number, mailing address, and website.
5. Enroll all Medicaid beneficiaries, except for excluded populations identified by the IDHW, into the Idaho Behavioral Health Plan upon eligibility determination. As used in this RFP, a Medicaid enrollee means a Medicaid Member who is enrolled in the Idaho Medicaid Management Information System (MMIS).
6. Determine the on-going eligibility of a person for Medicaid funded services.
7. Be responsible for all enrollment and disenrollment into the PAHP. The IDHW automatically enrolls Medicaid beneficiaries on a mandatory basis into the PAHP, for which it has requested a waiver of the requirement of choice of plans. There are no potential enrollees in this program because the IDHW automatically enrolls beneficiaries into the single PAHP. 42 CFR § 438.10(a)

#### B. Contractor's Responsibilities: The Contractor shall:

1. Administer behavioral health coverage for all Medicaid eligible Members. The Contractor

may not dis-enroll any Medicaid eligible Members.

2. Notify all Members, at the time of enrollment, of the Member's rights to change providers.
3. (AMENDMENT 1) Provide all Members, at the time of enrollment, all information required per 42 CFR § 438.10(f)(6) including, but not limited to:
  - a. (AMENDMENT 1) A provider roster of all providers in the Member's service area.
  - b. (AMENDMENT 1) Any restrictions on choosing a provider.
  - c. (AMENDMENT 1) Member rights and protections.
  - d. (AMENDMENT 1) The amount, duration and scope of benefits in sufficient detail to ensure Members understand their benefits.
  - e. (AMENDMENT 1) Procedures for obtaining benefits, including authorization requirements.
  - f. (AMENDMENT 1) The extent to which, and how, after-hours and emergency coverage are provided.
  - g. (AMENDMENT 1) Information on post-stabilization care.
  - h. (AMENDMENT 1) How to access transportation services.
4. Notify all Members, at least annually, of their rights provided under 42 CFR § 438.10(f)(6), 42 CFR § 438.10 (g) and 42 CFR § 438.10 (h) and written notice of any changes in the information specified in these provisions.
5. Ensure services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished consistent with requirements at 42 CFR § 438.210(a)(3)(i) as amended.
6. Not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the Member. 42 CFR § 438.210(a)(3)(ii).
7. (AMENDMENT 1) Comply with provisions of 42 CFR 438.210(a) (1)(2) and (4). The Contractor shall cover all medically necessary outpatient behavioral health services. The services must be of a quality that meets professionally recognized standards of care and must be substantiated by records including evidence of such medical necessity and quality. A service is medically necessary if:
  - a. (AMENDMENT 1) It is reasonably calculated to prevent, diagnose, or treat conditions in the Member that endanger life, cause pain, or cause functionally significant deformity or malfunction; and
  - b. (AMENDMENT 1) There is no other equally effective course of treatment available or suitable for the Member requesting the service which is more conservative or substantially less costly.
8. Defend, indemnify and hold harmless Members, the IDHW or its agents, employees or contractors against any and all claims, costs, damages, or expenses (including attorney's fees) of any type or nature arising from the failure, inability, or refusal of the Contractor to pay the behavioral health provider for covered services or supplies.
9. Designate a primary contact for the IDHW Contract Manager who will cooperate fully with

respect to the direction and performance of the contract.

10. Participate in a contract implementation meeting, either in person or by phone. The IDHW will facilitate the implementation meeting to review contract requirements and timelines. The Contractor shall attend this meeting and all meetings throughout the contract at its own expense.
11. (AMENDMENT 1) Comply with all provisions of state and federal laws, rules, regulations, policies, and guidelines as indicated, amended or modified that govern performance of the services. All references to federal and state statutes, rules, and regulations means the current version and as amended throughout the life of the contract unless otherwise noted. This includes, but is not limited to:
  - a. 42 CFR § 438.8(b) - requirements that apply to PAHP contracts
  - b. 42 CFR § 438.224 - HIPAA Protected Health Information
  - c. The IDHW's HIPAA Business Associated Agreement - Appendix E
  - d. Idaho statutes and administrative rules which can be accessed at [http://www.idaho.gov/laws\\_rules/](http://www.idaho.gov/laws_rules/)
12. Report to the IDHW's Contract Manager any facts regarding irregular activities or practices that may conflict with federal or state rules and regulations discovered during the performance of activities under the contract. Such information may also need to be reported to the Medicaid Fraud Control Unit and the Medicaid Program Integrity Unit as appropriate.
13. Maintain oversight, and be responsible for any functions and responsibilities it delegates to any subcontracted provider.
14. (AMENDMENT 3) Not subcontract with or employ individuals or entities that have been excluded by the federal government or by the IDHW, including but not limited to, the State's Medicaid program for fraud and abuse or who are included on the state's bad debt list. The state's bad debt list and the states termination list must be checked monthly by the Contractor. The Contractor is prohibited from subcontracting with providers who have been terminated by Idaho Medicaid or other states in accordance with 42 CFR § 455.416. The Contractor shall be responsible for checking the federal and state exclusion lists, on a monthly basis, of behavioral health providers currently excluded by the state and the federal government per the provisions of 42.CFR § 455.436.
15. Comply with the following: The Contractor is prohibited from (1) being an owner, in full or in part, of any organization participating as a behavioral health provider in the Medicaid program, or (2) having an equity interest in or being involved in the management of any behavioral health provider organization or entity. This also applies to family members of owners and managers, as well as to any administrative or management services subcontractors of the Contractor on this project.
16. (AMENDMENT 1) Ensure that all behavioral health services provided under this contract are provided by, or under the supervision of, at least a licensed master behavioral health clinician in the practice of his or her profession unless the service is provided at a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Indian Health Services (IHS) facility in which case, a Medical Doctor (MD) or Doctor of Osteopathy (DO) may supervise.
17. Act as the State's agent to collect Third Party Liability for all enrolled Medicaid recipients. The Contractor's capitated payments have been computed based on claim experience that

is net of these collections.

18. Ensure that any compensation, to individuals or entities that are subcontracted by the Contractor to conduct utilization management activities under this contract, is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Member per 42 CFR § 438.210(e).
19. Not prohibit, or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient for the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered. 42 CFR § 438.102(a)(1)(i)
20. Not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient, for any information the enrollee needs in order to decide among all relevant treatment options. 42 CFR § 438.102(a)(1)(ii)
21. Not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient, for the risks, benefits, and consequences of treatment or non-treatment. 42 CFR § 438.102(a)(1)(iii)
22. Not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient, for the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. 42 CFR § 438.102(a)(1)(iv)
23. Not provide, reimburse, or provide coverage for a counseling or referral service if Contractor objects to the service on moral or religious grounds. 42 CFR § 438.102(a)(2)
24. Notify the IDHW, in writing, when changes in key personnel of this contract occur, as well as other management and supervisory level staff. The Contractor shall provide the IDHW with resumes of the aforementioned individuals for review.
25. Notify the IDHW when there is a significant change in the Contractor's operations that would affect their ability to meet the required capacity and services. Operational changes may result in an amendment of the requirements, subcontracting to assure services are not disrupted for Members, or imposing the remedies identified in Appendix D - Special Terms and Conditions. A significant change includes, but is not limited to, changes in the Contractor's:
  - a. Services
  - b. Benefits
  - c. Geographic service area
  - d. Payments
  - e. Enrollment of a new population requiring services
26. Endorse and promote all therapeutic initiatives of the Idaho Medicaid Pharmacy and Therapeutics Committee and the Medicaid Pharmacy Program, including preferred drug list compliance, therapeutic guideline implementation and prior authorization criteria. The Contractor shall assist the IDHW with education to providers to drive implementation and compliance with pharmacy programs and shall not actively promote any programs or

initiatives that conflict with those of the IDHW.

27. If a network provider elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds per the provisions of 42 CFR § 438.102(a)(2), it shall furnish information about the services the provider does not cover, per the requirements at 42 CFR § 438.102(b)(1) as follows:
  - a. To the IDHW;
  - b. With its application to be a network provider;
  - c. Whenever it adopts the policy during the term of the contract;
  - d. It shall be consistent with the provisions of 42 CFR § 438.10; and
  - e. It shall be provided to Members within ninety (90) calendar days after adopting the policy with respect to any particular service.
28. The Contractor shall coordinate with the IDHW's contracted transportation broker and support IDHW requirements for Medicaid reimbursed transportation services by providing sufficient information when it is needed to justify use of transportation. The IDHW's contracted transportation broker administers, coordinates, and manages all non-emergency medical transportation (NEMT). For information on Idaho's NEMT services, go to the following website:  
<http://www.healthandwelfare.idaho.gov/Medical/Medicaid/MedicalCare/MedicalTransportation/tabid/704/Default.aspx>.
29. Develop and maintain an updated Policies and Procedures Manual for the services identified in this RFP. The Policies and Procedures Manual shall be available in electronic and hard copy upon request to the IDHW at no additional cost.
30. Participate in the IDHW's appeal and Fair Hearing processes when required by the IDHW.
31. (AMENDMENT 1) Submit, within thirty five (35) calendar days of request by the Secretary of Health and Human Services or the state, full and complete information regarding:
  - a. (AMENDMENT 1) The ownership of any subcontractor with whom the Contractor has had business transactions totaling more than twenty five thousand dollars (\$25,000.00) during the twelve (12) month period ending on the date of the request; and
  - b. (AMENDMENT 1) Any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any subcontractor, during the five (5) year period ending on the date of the request. 42 CFR § 455.105

## II. Administration and Operations

- A. The Contractor shall implement, administer and maintain the Idaho Behavioral Health Plan, an outpatient PAHP as defined in 42 CFR § 438.2, and related services for all eligible Medicaid Members, an outpatient prepaid ambulatory health plan (PAHP), as defined in 42 CFR § 438.2., that provides behavioral health coverage for all Medicaid eligible children and adults. The following populations are excluded:
  1. Those populations that are covered for premiums only;
  2. Undocumented aliens;
  3. Members who reside in State hospitals or institutions, except for discharge planning; and

4. Members enrolled in the Medicare-Medicaid Coordinated Plan (MMCP).
- B. The Contractor shall provide a behavioral health benefit package for children and adults that is based on cost effective, evidence-based standards of practice within the behavioral health community. Attachment 12 - Continuum of Care, provides a detailed description of Medicaid-reimbursed services and services that statewide behavioral health stakeholders have identified as necessary components of a robust continuum of care. The package for children and adults must include community based behavioral health services as well as rehabilitative services.
- C. The Contractor shall:
  1. Develop a robust continuum of care based on State Plan services;
  2. Pay providers in compliance with the prompt pay standards as follows:
    - a. Pay ninety percent (90%) of clean claims within thirty (30) days.
    - b. Pay ninety nine percent (99%) of clean claims within ninety (90) days.
  3. Develop and operate a complaint and grievance system which includes but is not limited to providing the IDHW with a Complaint and Grievance Resolution and Tracking Report;
  4. Educate Members and providers regarding all aspects of the Idaho Behavioral Health Plan;
  5. Hire, train, and maintain sufficient qualified staff to implement, administer, and manage the Idaho Behavioral Health Plan and all services related to the contract. Sufficiency shall be determined by comparison of baseline accessibility to changes in accessibility, Member complaints and quality assurance processes.
  6. Ensure that written material is in an easily understood language and format. Written material shall be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. The Contractor shall also ensure Members are aware of this availability. 42 CFR § 438.10:
  7. (AMENDMENT 3) Promote and monitor continuity of care standards between network behavioral health providers, PCPs, and other health care specialists and other services as needed (e.g., school, court system);
  8. Ensure verification of program eligibility for Members and providers;
  9. Process claims and prior authorize services when required;
  10. Promote the well-being of the population served through preventive and population-based behavioral health interventions;
  11. Provide general information and orientation regarding all aspects of the program and operations. The Contractor shall have in place a comprehensive program to provide all Members, not just those who access services, with appropriate information, such as information about behavioral health treatment services, available providers, and education related to recovery, resilience and best practices, as well as Member rights. In developing these materials, obtain input from consumers, secondary Member and/or family Members and other stakeholders who can contribute to both the content and presentation of the information so that the information is provided in a manner and format that may be easily understood per 42 CFR § 438.10(b)(1);
  12. Identify any new service offeror proposes to develop under the capitated rate as

cost-effective services per 42 CFR § 438.6(e) as determined by the IDHW. Later in the contract period, if the opportunity for 1915(b)(3) services becomes available, the Contractor should identify any impacts the services they proposed would have on the capitation rates set for the contract;

13. Implement new special services and programs when identified by the Contractor's cost-benefit analysis as approved by the IDHW and CMS (as necessary); and
14. Provide day to day business operations for the state of Idaho to ensure ongoing communication and interaction with IDHW staff to implement and maintain the services outlined in the RFP. Response should include, but not be limited to, meeting with IDHW staff on an ongoing basis, providing ongoing support and interaction with network providers, and working with stakeholders. The IDHW will not provide work space for the Contractor's staff.

### III. Work Plan and Service Implementation

- A. The Contractor shall provide and utilize a Work Plan for service implementation of the Idaho Behavioral Health Plan.
- B. The Contractor shall immediately begin to collaborate with the IDHW after the contract is fully executed to work toward a timely implementation period. The implementation period shall be complete within six (6) months of the contract execution date. The preferred implementation date of services is July 1, 2013.
- C. The Contractor shall establish an implementation team that shall ensure the plan for implementation of services progresses according to the required timelines. The Contractor shall meet with the IDHW within the first five (5) business days of the contract execution date to establish the following deliverables and to establish priorities.
  1. The Contractor is responsible for any costs they may incur for all meetings during the implementation process.
- D. The Contractor shall:
  1. Define the project management team, the communication paths and reporting standards between the IDHW and the Contractor staff;
  2. Establish a written comprehensive Work Plan, including the schedule for key activities and milestones which is a part of the Contractor's overall Work Plan;
  3. Define expectations for content and format of contract deliverables.
- E. The Contractor shall develop and maintain a comprehensive written Work Plan which shall include timelines. The Work Plan is due within ten (10) business days of the execution date of the contract and shall include time frames for critical milestones for implementation. The Work Plan shall clearly include all tasks necessary to meet the requirements of the RFP and shall include timeframes for critical milestones for implementation. It shall clearly specify the Contractor's understanding of information to be provided by the IDHW. The Work Plan shall include the following Contractor tasks and plans:
  1. Schedules and timetables for implementation;
  2. A detailed description of the implementation methods;
  3. Communication Plan that includes a plan to communicate with Members, providers and stakeholders, including Member service and provider service call centers and Member and provider handbooks;

4. Website Development Plan;
  5. Network Development Plan, including analysis and plans to effect a smooth transition;
  6. Service Transition Plan;
  7. A Staffing Plan identifying hiring expectations and staff associated with each task of the implementation period and the work of the contract itself; the Contractor should describe how they would make use of the following positions: Contract Manager, Chief Financial Officer, Chief Medical Officer, Outcomes or Quality Improvement Director, Member and Family Affairs Director, Account Manager, Project Manager, Business Analysis Lead, Systems Analysis Lead, Systems Manager, Data Conversion Manager, Testing Lead, Training Lead, Documentation Lead;
  8. Training Plan for Contractor staff, IDHW staff, Members, providers, and stakeholders;
  9. Facilities, Fiscal Requirements and Cost Avoidance Plans;
  10. Quality Management Plan;
  11. Utilization Management Plan, including outlier management and plans for care coordination;
  12. Complaints, Grievances and Appeals Plan;
  13. Customer Service System Plan;
  14. Overall Project Plan, including reports and interface plans, claims processing and information management integration, hardware and equipment acquisition and installation, operating system and software installation, systems testing, etc.;
  15. Business Continuity, Disaster Recovery, and Risk Management Plan;
  16. Contract Compliance Plan; and
  17. Operational Readiness Plan.
- F. In addition to those items specifically enumerated above, the Contractor shall develop and execute plans that ensure completion of all necessary tasks, explicit or implicit, assigned to the Contractor by this RFP. Such plans shall be made available to the IDHW when completed and whenever updated.
- G. The Contractor shall utilize their Contract Manager, or a designee to be responsible for successful completion of Contractor's responsibilities and overseeing and monitoring the Contractor's staff on a day-to-day basis as they undertake project activities. The Contract Manager, or designee, shall also work closely with the IDHW Contract Manager and assist in coordinating IDHW resources. The Contractor's Contract Manager, or designee, shall maintain the Work Plan.
- H. The Contractor's Contract Manager, or designee, and relevant contract staff shall meet with and provide project status to the IDHW Contract Manager and other IDHW staff weekly. The purpose of the status meetings is for the Contractor to communicate actual progress, identify problems, recommend courses of action, and obtain approval for making modifications to the Work Plan. In conjunction with the project status meetings, the Contractor shall provide written status reports to the IDHW's Contract Manager at least every two weeks during implementation. This status report shall include:

1. Updated Work Plan and responsibility matrix.
  2. Tasks that are behind schedule.
  3. Dependent tasks for tasks behind schedule.
  4. Items requiring the IDHW Contract Manager's attention.
  5. Anticipated staffing changes.
  6. Risk assessment.
  7. Any issues that can affect schedules for project completion.
  8. Identification, time frames, critical path effects, resource requirements and materials.
- I. The Contractor shall:
1. Be responsible for documenting all meetings, including attendees, topics discussed, decisions recommended and/or made with follow-up details. Written minutes and summaries from all meetings are to be provided to the IDHW Contract Manager no later than three (3) business days after the date of each meeting;
  2. Provide a written project communication plan, the purpose of which is to keep contract management and staff informed about all information they need to complete assigned responsibilities, as well as to keep all system stakeholders proactively informed on the progress of the project.
  3. Prepare and submit, in its Work Plan, a comprehensive set of flow diagrams that clearly depict the proposed final work operations, including but not limited to, Member flow, Contractor workflow, expected IDHW workflow, data flow and authorization and provider payment process. These diagrams shall aid in the understanding of how the Contractor will perform work and support training. The level of detail in these diagrams shall be sufficient to communicate to the Members and providers their roles in the behavioral health managed care process. With a goal to maximize clarity, the Contractor shall use graphical software that matches what the IDHW currently uses as its platform.
  4. The Contractor shall demonstrate its readiness and ability to provide covered behavioral health services and to resolve any previously identified operational deficiencies. The Contractor shall undergo and must pass a two (2) phase readiness review process and be ready to assume responsibility for contracted behavioral health services within one-hundred eighty (180) calendar days of the effective date of the contract. See Attachment 9 - Initial Deliverables and Attachment 10 - Readiness Review, for a detailed description of expectations for the two (2) phase readiness review.
- J. The Contractor shall:
1. Ensure the health and safety of Idahoans is not put at risk during the transition in administration from the fee-for-service reimbursement model to the managed care model of service delivery;
  2. Ensure major components of the current network delivery system are not adversely affected by transition to managed care;
  3. Honor existing Member-therapist relationships to the greatest extent possible;
  4. Effect transfers in care as seamlessly as possible to Members;

5. Allow a transfer process with sufficient time for Members to receive notifications, make choices when choices are available, and ask questions of the Contractor regarding the transfer process and the Member's Idaho Behavioral Health Plan benefits;
6. Ensure the provider network:
  - a. Is sufficiently informed of the Contractor's administrative requirements for participation in the network and for delivery of benefits to Members provided under the Idaho Behavioral Health Plan;
  - b. Is able to deliver services according to the Contractor's standards and all state and federal requirements;
  - c. Is scheduled according to the Contractor's established timelines for "go live" activation.

IV. Behavioral Health Services

- A. The Contractor shall provide a recovery oriented system of care that is holistic and includes the following categories of mandatory State Plan services:
  1. Community based outpatient
  2. Rehabilitation
  3. Substance use disorders
- B. The Contractor shall ensure the more stringent requirements for SUDS treatments regarding confidentiality (42 CFR Part 2) are incorporated into the Contractor's policies and procedures as well as the requirements for the network of providers.
- C. The Contractor may place appropriate limits on a service:
  1. On the basis of medical necessity criteria (Medical necessity is defined in IDAPA 16.03.09, The IDHW shall be the final authority regarding all disputed medical necessity decisions.); or
  2. For the purpose of utilization control, provided the services furnished can be reasonably expected to achieve their purpose. 42 CFR § 438.210(a)(3)(iii.)
- D. The Contractor shall:
  1. Promote and assist in the recovery of adult Members with serious mental illnesses (SMI) and those with serious and persistent mental illness (SPMI) and resiliency of child Members with serious emotional disturbance (SED) and/or co-occurring substance use disorders through innovative services that empower Members, and families as appropriate, to determine and achieve their goals; this includes specific attention to behavioral health service needs of very young children as described in Attachment 15 - Infant Toddler Mental Health.
  2. Utilize and implement evidence-based practices in service delivery and describe how you will demonstrate fidelity to the tested model used for each evidence-based practice, when available, in order to assure the effectiveness of the service provided. Such fidelity should be applied except when adjustment is specifically described and justified for good cause, such as administering the practice in rural areas or to account for cultural differences. Information on sources for five (5) of the adult evidence-based practices, including fidelity checklists, and evidence-based practices applicable for children, is available on the SAMHSA website at <http://www.nrepp.samhsa.gov>.
  3. Provide culturally competent community-based services, including evidence-based, best practices, trauma-informed care and alternative services for Members of all ages. See

Attachment 18 - Trauma-informed Care for more a detailed description of trauma-informed care.

4. Provide Members with timely access to a comprehensive array of specialized behavioral health services delivered by culturally-competent, qualified service providers.
  5. Ensure that services reflective of continuous quality improvement are provided to Members, and families as appropriate.
  6. Provide all necessary services through a cost-effective system.
  7. Achieve a coordinated system of delivering medically necessary covered behavioral health services to Members.
  8. Maximize community resources in an effort to maintain the least restrictive level of care.
  9. Ensure provision for a second opinion from a qualified behavioral health care professional within the network, or arrange for a second opinion outside the network, at no cost to the Member per 42 CFR § 438.206(b)(3) and must occur within seven (7) calendar days from the date it is requested.
  10. Cover those services out-of-network for the Member for as long as the Contractor is unable to provide them by a network provider in the event that the network is unable to provide necessary services covered under the contract for a particular member, per 42 CFR § 438.206(b)(4).
  11. Coordinate with out-of-network providers with respect to payment and ensure that cost to the Member is no greater than it would be if the services were furnished within the network.
  12. Track and report Members' movement from one (1) level of care to another on a quarterly basis.
- E. The Contractor shall manage potential influences on the administration of behavioral health services under the PAHP, including the following:
1. Each region features a different mix of professional expertise and community volunteerism, and the array of services might be achieved through different types of venues or may have a different configuration from one region to another;
  2. Services will be available in all areas of the state, but the prevalence of any service may vary among regions as appropriate to reflect the needs of a region's targeted population;
  3. Working with regional behavioral health advisory boards to develop local access standards using their own demographics, geography, and availability of services within pocketed areas of a particular region;
  4. The Contractor may need to establish arrangements across regions to help make a service available that is not available in a certain region;
  5. While initially it may only be possible that the Contractor provides services in areas where there are already services, the expectation is that the Contractor will engage in long term planning with regional behavioral health advisory boards to develop a full continuum of services across all areas of the state.

V. Member Enrollment/Disenrollment

- A. The Contractor shall use the IDHW's Medicaid Management Information System (MMIS)

eligibility to identify Medicaid eligible Members on a daily basis.

- B. The Contractor shall:
1. Accept Members in the order in which they are enrolled, without restriction;
  2. Not discriminate against Members eligible to enroll on the basis of health status or need for health care services, race, color, or national origin per 42 CFR § 438.6(d)(3);
  3. Not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin per 42 CFR § 438.6(d)(4);
  4. Not request disenrollment of any Member for any reason, including requests because of a change in the Member's health status, or because of the Member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. 42 CFR § 438.56(b)(2);
  5. Not disenroll Members for any reason. The Contractor may propose a disenrollment to the IDHW, but the IDHW will make the final determination;
  6. Eligible Members may not disenroll from the Idaho Behavioral Health Plan, but the IDHW may disenroll Members whose eligibility changes to a Medicaid coverage group excluded from the PAHP, or who otherwise lose Medicaid eligibility, consistent with the terms of this contract and the related waiver;
- C. The Contractor shall not request disenrollment of Members for any reason and shall be consistent with the IDHW's policy that there will be no circumstances in which a qualified Member is disenrolled. 42 CFR § 438.56(b)(1) and (3).

VI. Coverage and Payment for Post-Stabilization Services

- A. The Contractor shall provide post-stabilization services as defined in 42 CFR § 438.114(a) and (b) and ensure the services are covered and paid for in accordance with the following provisions:
1. Be financially responsible for medically necessary post-stabilization services that are pre-approved by an Idaho Behavioral Health Plan provider or other Idaho Behavioral Health Plan representative that the Contractor has authorized to make pre-approval decisions;
  2. Be financially responsible for medically necessary post-stabilization services obtained within or outside the network that are not pre-approved, but administered to maintain the Member's stabilized condition within one (1) hour of a request to the Contractor for pre-approval of further post-stabilization covered services.
- B. The Contractor shall be financially responsible for medically necessary post-stabilization services obtained within or outside the network that are not pre-approved, but administered to maintain, improve or resolve the Member's stabilized condition if the Contractor:
1. Does not respond to a request for pre-approval within one (1) hour;
  2. Cannot be contacted; or
  3. And the treating physician cannot reach an agreement concerning the Member's care and the Contractor's physician is not available for consultation. In this situation, the Contractor shall give the treating physician the opportunity to consult with the Contractor's physician and the treating physician may continue with care of the Member until the Contractor's physician is reached.

- C. The Contractor's financial responsibility for medically necessary post-stabilization covered services it has not pre-approved ends when:
  - 1. A network physician assumes responsibility for the Member's care through transfer; and
  - 2. The Contractor's representative and the treating physician reach an agreement concerning the enrollee's care.

VII. Access to Care

- A. The Contractor shall ensure services are provided through a well-organized service delivery system. The service delivery system shall include mechanisms for ensuring access to high quality, general and specialized care, from a comprehensive provider network. Mechanisms for access shall include opportunities for face-to-face inquiries, a twenty four (24) hour per day toll free telephone line, and electronic communication mediums.
- B. The Contractor shall ensure access to medically necessary covered behavioral health services for Members, and families as appropriate, including engaging Members with serious mental illness, serious and persistent mental illness and/or co-occurring substance use disorder who may not seek help on their own.
- C. The Contractor shall:
  - 1. Ensure access to care for all Members in need of covered behavioral health services through the provision of the following:
    - a. Varied geographic location of providers;
    - b. Providers located within thirty (30) miles or within thirty (30) minutes of travel within Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock and Bonneville counties and within forty five (45) miles or within forty five (45) minutes in all other counties. Where this standard is not achievable, the Contractor shall develop plans for moving toward achieving this standard; such planning is subject to IDHW oversight. Use of telehealth technology is encouraged;
    - c. Use of local providers whenever possible to minimize need for travel and promote local cultural competency;
    - d. Appropriate Member to provider ratio for all services in every region of the state, consistent with industry standards;
    - e. Ensure sufficient numbers of prescribers/psychiatrists are available in the state; and
    - f. Make use of licensed psychologists to extend network capacity.
  - 2. Ensure services to Members are uninterrupted.
  - 3. Adhere to professional standards for determining staffing patterns in all settings.
  - 4. Ensure minimum hours of provider operation are sufficient in each time zone in Idaho to meet the needs of the population served in each location, which includes crisis coverage twenty-four (24) hours a day, seven (7) days a week, three hundred sixty five (365) days per year. Sufficiency shall be determined by comparison of baseline access to changes in access, Member complaints, and quality assurance processes.
  - 5. Provide hours of operation and service coverage in every region at sufficient locations to meet the needs of the population in each region, which may include additional morning, evening or weekend hours, to accommodate Members who are unable to attend appointments during standard business hours.

6. Ensure network providers offer flexibility of appointment times to Members whenever possible.
  7. Provide community-based access to increase accessibility and improve outcomes to ensure behavioral health services are provided in multiple community-based venues, based on a determination that the services:
    - a. Are medically necessary;
    - b. Are appropriate to the Member's needs and are not duplicative of other services the Member is receiving; and
    - c. Do not put the provider's safety at undue risk when provided in alternative treatment sites. Alternative treatment sites may include, but are not limited to,
      - i. Schools;
      - ii. Federally Qualified Health Centers;
      - iii. Homeless shelters;
      - iv. Assisted living facilities; and
      - v. Members' homes.
- D. The Contractor shall:
1. Provide evening and weekend support services for Members and families that include access to clinical staff, not just an answering service or referral service staff.
  2. Provide access to a twenty four (24) hour, seven (7) days per week, three hundred sixty five (365) days per year, toll-free line dedicated to Members that meets the following minimum standards:
    - a. The toll-free number shall be approved by the IDHW;
    - b. The Member line shall be answered by a live voice at all times;
    - c. All phone calls, voice mail and email shall be responded to on the same or next business day.
  3. (AMENDMENT 3) Identify Members who unexpectedly miss appointments or discontinue treatment. Appropriate and timely steps shall be taken to contact Members to determine if there is a problem that can be resolved and to promote continuation of services. The Contractor shall recognize that different strategies and levels of effort are appropriate for different populations (e.g. age groups, diagnosis, severity of illness, culture, language, etc.) promote and monitor outreach efforts that are appropriate for different populations, using numerous attempts and multiple methods that could include mail, telephone, e-mail, text messaging, home visits, or other efforts that are reasonably calculated to ensure verifiable contact.
- E. The Contractor should establish clear and specific criteria for discharging Members from treatment and criteria should be included in Member materials and information. Ensure criteria for discharge, established with Member input, is agreed upon by Member and Provider and should be noted in the Member's health care record and modified, by agreement, as necessary.
- F. The Contractor shall meet industry standards for access in the following categories, including

timeframes and types of professionals. Placing Members on waiting lists for initial routine service requests is not acceptable.

1. Capacity for crisis response and service authorization;
2. Life-threatening crisis intake and intervention services;
3. Non-life-threatening crisis intake and intervention services;
4. Urgent care, including urgent medication management;
5. Access to board certified physicians to provide clinical consultation for network providers, including a psychiatrist. Describe any special accommodation for children.
6. Access to board certified physicians to provide clinical consultation for PCPs, including a psychiatrist. Describe any special accommodations for children.
7. Routine appointments; and
8. Outpatient follow-up appointments after discharge from an inpatient psychiatric hospitalization or residential facility. Refer to Post-Stabilization Services for related requirements.

G. The Contractor shall:

1. Ensure the Member line is answered by a live voice at all times;
2. Assist and triage callers who may be in crisis by effectuating an immediate transfer to at least a licensed masters level care manager. The call shall be answered within thirty (30) seconds and only transferred via a warm line to at least a licensed masters level care manager;
3. (AMENDMENT 1) Respond to Members with limited English proficiency through the use of bilingual/multicultural staff or language assistance services. Bilingual/multi-cultural staff, at a minimum, shall speak English and Spanish and any other language spoken by at least five percent (5%) of the eligible population. The Contractor shall make oral interpretation services available free of charge to each Member in need of such services. The Contractor shall notify Members that oral interpretation is available for any language and written information is available in English and Spanish, and inform the Members how to access such services 42 CFR § 438.10(c);
4. Ensure every reasonable effort is made to overcome any barrier that Members may have to receiving services, including any language or other communication barrier;
5. Ensure network providers have staff available to communicate with the Member in his or her spoken language, and/or access to a phone-based translation service so that someone is readily available to communicate orally with the Member in his or her spoken language;
6. Have available, at all times, a Telecommunications Device for the Deaf (TDD) and/or relay systems;
7. Interact with callers in a courteous, respectful, polite, culturally responsive, and engaging manner;
8. Respect the caller's privacy during all communications and calls;
9. Adhere to all regulatory confidentiality requirements, ensure call tracking and record keeping is established and utilized for tracking and monitoring phone lines, including

tracing calls when appropriate, to ensure the safety of the Member or others;

10. Ensure calls received on the Member line are reported monthly to the IDHW per the requirements of the contract.

VIII. Cultural Competency

- A. The Contractor shall provide culturally competent behavioral health services to its Members, consistent with standards described at 42 CFR § 438.206(c)(2).
  1. The Cultural Competency Plan shall outline clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services with specific focus on Native Americans' and Hispanics' needs, and includes a positive statement that the Contractor shall have sufficient staff with cultural competency to implement and oversee compliance with the Cultural Competency Plan.
- B. The Contractor shall:
  1. Identify Members whose cultural norms and practices may affect their access to health care and its plan to outreach these Members;
  2. Recruit and retain qualified, diverse and culturally competent clinical staff within your provider network and include a positive statement that the Contractor will offer single case agreements to culturally competent staff outside of its network, if required to meet a Member's needs;
  3. Work with Native American and Hispanic providers to promote the development of these culturally specialized networks of providers;
  4. Monitor whether or not language services are being provided to all Members, upon request, and how it will address gaps or inadequacies found.

IX. Customer Service System

- A. The Contractor shall provide a customer service system that includes implementation of a Customer Service System Plan. The Customer Services System Plan must include services that meet the requirements at 42 CFR § 438.10(f)(6).
- B. The Contractor's Customer Service System Plan shall include a Call Center and Help Desk, policies on customer service, and identify how staff will be trained to meet the customer service requirements.
- C. The Contractor shall:
  1. Ensure that a toll-free number dedicated to customer service inquiries is established and publicized throughout Idaho and ensure multiple lines are available to accommodate Members, providers, IDHW staff and others that may be calling. The IDHW shall own the rights to the toll-free call center number at the conclusion of the contract;
  2. Maintain sufficient equipment and staff to meet the customer service requirements;
  3. Ensure no calls, e-mails or correspondence go unanswered (e-mails and other written correspondence shall be answered within two (2) business days);
  4. If an automated Interactive Voice Response (IVR) system is used, the system shall be programmed to answer all calls within three (3) telephone rings;
  5. The average daily hold time after initial automated response is two (2) minutes or less;

6. Provide periodic live monitoring of service calls for quality management purposes;
  7. Ensure call tracking and record keeping is established and utilized for tracking and monitoring phone lines;
  8. Ensure customer service inquiries are reported monthly to the IDHW per the requirements of the contract. All customer service communications, written or verbal, shall be reflected in the report.
- D. Should the Contractor choose to use an IVR the Contractor shall:
1. Provide an up-front message in the phone system to inform users when the system is down or experiencing difficulties, including an indication when the system is expected to be operational;
  2. Roll incoming calls to the Call Center staff during those instances when the system is unavailable during the hours the Call Center is staffed;
  3. For IVR users who are seeking data, verify that the person using IVR is an authorized user, and allow access to data by Member ID number, social security number, or Member name and date of birth;
  4. Assign and provide the user a unique identifier for each inquiry;
  5. Provide appropriate safeguards to protect the confidentiality of all information, in compliance with federal, State and IDHW confidentiality laws, including HIPAA;
  6. Provide toll-free telephone number(s);
  7. Integrate with the Call Center and Help Desk to provide IVR users with an option for customer service representative support when requested during the hours the Call Center is staffed;
  8. Provide sufficient in-bound access lines to ensure IVR users:
    - a. Are connected with the IVR system within three (3) telephone rings at least ninety-nine percent (99%) of the time;
    - b. When transferred are connected with the IVR system within ten (10) seconds, ninety-nine percent (99%) of the time;
    - c. Receive a busy signal less than five percent (5%) of the time they call;
    - d. Are not dropped in excess of zero-point-five percent (0.5%) of the total daily call volume; and
    - e. Are successfully transferred to live assistance at the Call Center in less than one-hundred-twenty (120) seconds of request to transfer;
    - f. Call abandonment rates should not exceed seven percent (7%);
  9. Ensure that the IVR is available for information and service requests twenty (24) hours a day, seven (7) days a week, three hundred sixty five (365) days per year except for IDHW approved scheduled downtime;
  10. Resolve all IVR system downtimes caused by the IVR hardware, software, or other components under the Contractor's control, within thirty (30) minutes of initial notification of

system failure. If the system is not in service within that time frame, the Vendor shall provide a failover IVR system to ensure that system downtime is limited to a maximum of thirty (30) continuous minutes;

11. Maintain and retain for twenty-four (24) months, electronic records of all IVR inquiries made, information requested, and information conveyed;
12. Make updates to the IVR recorded responses within two (2) business days of receiving a request from the IDHW.

E. The Contractor shall:

1. Manage the Call center and Help Desk function and ensure staff are trained to provide customer service response to inquiries;
2. Utilize a language line translation system for callers whose primary language is not English;
3. Have available, at all times, a Telecommunications Device for the Deaf (TDD) and/or relay systems;
4. Interact with callers in a courteous, respectful, polite, culturally responsive, and engaging manner;
5. Respect the caller's privacy during all communications and calls;
6. Assist callers with issues and concerns regarding service referrals, authorizations, payments, training, or other relevant inquiries, regarding service provision, eligibility or payment; a separate provider services line is also permitted to address provider issues;
7. Work with callers to provide referrals to obtain eligibility for other supportive services, such as, but not limited to, community organizations. For complex matters, callers should be referred to the Contractor's care management staff;
8. Facilitate access to information on available service requirements and benefits.

X. Provider Network Development and Management Plan

- A. As part of the implementation process, the Contractor shall implement a Provider Network Development and Management Plan for transforming the current service delivery system into a comprehensive system.
- B. The Contractor's Network Development and Management Plan shall clearly identify a plan for transforming the current service delivery system into a comprehensive system that:
  1. Includes qualified service providers and community resources designed and contracted to deliver behavioral health care that is strength-based, family-focused as appropriate, community based, and culturally competent.
  2. Is of sufficient size and scope to offer Members a choice of providers for all covered behavioral health services.
  3. Ensures behavioral health services are uniformly available throughout the state incorporating recognized evidence-based practices, best practices, and culturally competent services that promote recovery and resiliency through nationally recognized integrated service models.
  4. Increases access to family and community-based services and reduces reliance on higher

cost services.

5. Includes the needs of all Members identified in the scope of the PAHP and includes the following:
    - a. A fully operational network of psychiatric crisis response providers available twenty four (24) hours per day, seven (7) days per week, three hundred sixty five (365) days per year, prior to completion of the Readiness Review.
    - b. Within nine (9) months after the date of the implementation of services the Contractor shall conduct a statewide needs assessment to identify and quantify gaps in the array of State Plan services and in the network provider types, describe the challenges presented by such gaps, and then design an innovative solution for addressing the unmet service needs that is not limited to the agency/clinical model of service delivery. This solution shall be submitted by the Contractor to the IDHW within twelve (12) months after the implementation of services.
  6. Ensures there are a sufficient number of accessible qualified interpreters. Sufficiency shall be defined as baseline accessibility compared to changes in accessibility, Member complaints and quality assurance processes.
- C. The Contractor shall provide and maintain a database that contains real-time information identifying, according to ZIP code and by provider type, office hours, contracted capacity and out-of-region or out-of-network service alternatives. The IDHW shall have access to this database.
- D. The Contractor shall solicit input from the members of the provider network regarding their satisfaction with participating in the Contractor's network.

XI. Provider Network

- A. The Contractor shall implement and maintain a network of providers, including psychiatrists, to deliver behavioral health treatment, rehabilitation, and support services, while optimizing the use of natural and informal supports that meet the needs of Members. The Contractor's network of providers shall assure the health, safety, and appropriate treatment of Members.
- B. The Contractor shall design the network to deliver culturally and linguistically (including the Member's prevalent language(s) and sign language) appropriate services in home and community-based settings and assist Members to achieve their recovery goals or treatment plans.
- C. The Contractor shall enter into written subcontracts with qualified service providers to deliver covered behavioral health services to Members. See Attachment 5 - Network Provider Subcontracts for minimum requirements for the subcontracts.
- D. The Contractor shall require providers to:
  1. Obtain a unique national provider identifier (NPI).
  2. Operate within their license and scope of practice.
  3. Obtain and maintain all applicable insurance coverage, in accordance with the Terms and Conditions of the contract.
- E. The Contractor is not obligated to contract with any provider agency or individual practitioner unable to meet contractual standards (see exceptions for FQHCs in section S and Tribal providers in section T). The Contractor shall provide written notice to any individual, facility or agency that applies to be part of the Contractor's network but is not enrolled. The notice shall

include the reason(s) the applicant was not accepted into the network. The Contractor shall provide written notice to each network provider the Contractor chooses to end a contract with and shall state the reason for ending the contract. 42 CFR § 438.12(a)(1) and (b) (1).

- F. The Contractor is not obligated to continue to contract with a provider agency or individual practitioner who does not provide services reflective of continuous quality improvement or who demonstrates utilization of services that are an outlier compared to providers with similarly acute populations and/or compared to the expectations of the Contractor and the IDHW.
- G. The Contractor's provider agency and individual practitioner selection policies and procedures cannot discriminate against particular provider agencies or individual practitioners that serve high-risk populations or specialize in conditions that require costly treatment.
- H. The Contractor may not discriminate for the participation, reimbursement, or indemnification of any provider agency or individual practitioner who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the Contractor declines to include provider agencies or individual practitioners in its network, it shall give the affected provider agencies and individual practitioners written notice of the reason for its decision. 42 CFR § 438.12(a)(1). This section may not be construed to:
  - 1. Require the Contractor to contract with provider agencies or individual practitioners beyond the number necessary to meet the needs of its enrollee.
  - 2. Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.
  - 3. Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to Member. 42 CFR § 438.12(b)
- I. The Contractor shall develop and implement written policies and procedures for the selection and retention of providers per 42 CFR § 438.214(a) and ensure the network of providers is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Members in the service area per 42 CFR § 438.207(b). The Contractor shall provide the policies and procedures to the IDHW when requested. The policies and procedures may be reviewed during the Readiness Review process. These policies and procedures shall include, at a minimum, the following:
  - 1. A documented process for receiving requests for initial services and continuing authorization of services per 42 CFR § 438.214(b)(1);
  - 2. A documented process for credentialing and re-credentialing of providers who have signed contracts or participation agreements with the Contractor per 42 CFR § 438.214(b)(2);
  - 3. The Contractor's provider selection policies and procedures, consistent with 42 CFR § 438.214(c), shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;
  - 4. The Contractor may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act and per 42 CFR § 438.214(d);
  - 5. Requirement that criminal conviction information for anyone who has ownership or control interest in the provider, or is an agent or managing employee of the provider as per 42 CFR § 455.106 shall be disclosed; and
  - 6. Disclosure of owners, per 42 CFR § 455.104(b)(2), who own five percent (5%) or more in

this provider entity (42 CFR § 455.104(a)(2)) shall be disclosed to the IDHW including the following:

- a. All managing employees of the disclosing entity (provider) as defined in 42 CFR § 455.101;
  - b. Subcontractor in which a practitioner has direct or indirect ownership of five percent (5%) or more per 42 CFR § 455.104(b)(2);
  - c. List ownership of any subcontractor with whom this provider has had business transactions totaling more than twenty five thousand dollars (\$25,000) during the previous twelve (12) month period per 42 CFR § 455.105;
  - d. List persons that are related to each other (spouses, parents, children, or siblings); and
  - e. Identification of persons with criminal offenses for criminal offenses related to the person's involvement in any program under Medicare, Medicaid, or Title XX, per 42 CFR § 455.100 and 42 CFR § 455.106.
- J. The Contractor shall not restrict or inhibit providers in any way from freely communicating with or advocating for a Member regarding behavioral health, medical needs, and treatment options, even if the Member needs services that are not covered or if an alternate treatment is self-administered. The Contractor may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient:
1. For the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
  2. For any information the Member needs in order to decide among all relevant treatment options.
  3. For the risks, benefits, and consequences of treatment or non-treatment.
  4. For the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- K. The Contractor shall require providers to communicate information to assist a Member to select among relevant treatment options, including the risks, benefits, and consequences of treatment or non-treatment; the right to participate in decisions regarding his or her behavioral health care; and the right to refuse treatment and to express preferences about future treatment decisions.
- L. The Contractor shall:
1. Ensure the provider network is sufficient in size and composition to meet the needs of Members, per 42 CFR § 438.206(b)(1), based on the following factors:
    - a. Growth trends in eligibility and enrollment.
    - b. Best practice approaches.
    - c. Accessibility of services including:
      - i. The number of current qualified service providers in the network who are not accepting new referrals.
      - ii. The geographic location of providers and Members considering distance, travel time, and available means of transportation.
      - iii. Availability of services with physical access for persons with disabilities.

- iv. Cultural and linguistic needs, including the Member's prevalent language(s) and sign language.
- 2. Maintain a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract per 42 CFR § 438.206(b)(1). In establishing and maintaining the network, the entity shall consider the following:
  - a. The anticipated Medicaid enrollment.
  - b. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular contract.
  - c. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services.
  - d. The numbers of network providers who are not accepting new Members.
  - e. The geographic location of providers and Members, considering distance, travel time, the means of transportation ordinarily used by Members, and whether the location provides physical access for Members with disabilities.
- 3. Ensure at least as much access to services as exists within Medicaid's fee-for-service program.
- 4. Establish the initial managed care provider network by drawing from the pool of the existing enrolled Medicaid behavioral health agencies that have either successfully achieved Medicaid credentialing or national accreditation in addition to any other qualified practitioners that may or may not have ever delivered services to Members. Network providers shall meet the standards set by the Contractor and IDAPA and be in compliance with all federal and state requirements, including not being on the federal and state exclusion lists.
- 5. Perform credentialing and re-credentialing of qualified service providers in order to ensure they meet the accreditation requirements set by the Contractor and compliance to IDAPA, state and federal statutes.
- 6. Implement and maintain written credentialing and re-credentialing policies consistent with federal and state regulations for selection and retention of providers, credentialing and re-credentialing, and nondiscrimination. 42 CFR § 438.214;
- 7. Contract with providers of behavioral health services who are appropriately licensed and/or certified and meet the Contractor's criteria for network enrollment including completion of a Network Provider Subcontracts. See Attachment 5 - Network Provider Subcontracts.
- 8. Evaluate every prospective individual practitioner's ability to deliver behavioral health services in the continuum of care prior to contracting with any provider agency that employs such practitioners.
- 9. Identify the gaps in services and access, and implement solutions to resolve the issues.
- 10. Develop and recruit culturally informed Native American and Hispanic practitioners into the provider network to provide services.
- 11. Whenever possible, ensure Members have a choice of providers, to the extent possible,

which offer the appropriate level of care. (42 CFR § 438.6(m)) Exceptions would involve highly specialized services which are usually available through only one (1) agency or provider in the geographic area. Members may change providers.

12. Honor existing Member/provider relationships as much as possible in the newly established network. If a change is necessary, the Contractor shall ensure a seamless transition of services or providers.
13. Pursuant to Early Periodic Screening, Diagnosis and Treatment (EPSDT) requirements, if a child under the age of twenty one (21) needs a specialized medically necessary service that is not available through the network, the Contractor shall arrange for the service to be provided outside the network by a qualified provider.
14. Maintain a list of current network providers that is available to Members, the Member's family/caregiver and referring providers in hard copy and electronically. The list shall specify providers who are able to deliver services in languages other than English.
15. Conduct an Annual Network Inventory and provide a written report to the IDHW by a date determined by the IDHW. The first inventory due date will be relative to the implementation of services date of the Idaho Behavior Health Plan. The Contractor shall prepare the network inventory to quantify the number of qualified service providers, including the crisis response providers, available within the network as follows:
  - a. Each category of covered behavioral health services as identified by the IDHW.
  - b. Specialty behavioral health service providers, including providers with expertise to deliver services to persons with developmental disabilities, non-English speaking persons, and other specialties as identified by the IDHW.

## XII. Notification Requirements for Changes to the Network

- A. The Contractor shall notify and obtain written approval from the IDHW before making any material changes in the size, scope, or configuration of its network, as described in the Contractor's Network Development and Management Plan. A material change includes any event that affects service delivery and includes a reduction in workforce at a qualified service provider level; any plan to not fill, or delay filling, staff vacancies; or termination of a subcontract, the crisis provider and other qualified providers. The Contractor shall notify the IDHW, in writing within one (1) business day of the Contractor's knowledge of an expected, unexpected, or anticipated material change to the network or a network deficiency that could affect service delivery, availability, or capacity within the provider network. The notice shall include:
  1. Information describing how the change will affect service delivery, availability, or capacity of covered behavioral health services.
  2. A plan to minimize disruption to the behavioral health Member's care and service delivery.
  3. A plan for clinical team meetings with the behavioral health Member and his or her family/caregiver as appropriate to discuss available options and revise the treatment plan to address any changes in services or service providers.
  4. A plan to correct any network deficiency.
- B. Should a provider be terminated from the network for cause, the Contractor ensure this information is reported to the Medicaid Program Integrity Unit as well as the IDHW Contract Manager.
- C. The Contractor shall utilize performance and quality assurance data when determining to

retain providers. Describe the criteria to be used for making the determination to terminate a network provider.

- D. The Contractor shall notify a network provider in writing when a determination is made to terminate a provider from the network and ensure prior written notice includes details pertaining to the decision to terminate. Submit a sample of a termination notice with your proposal.
- E. The Contractor shall ensure the IDHW is notified within two (2) business days if a provider fails to meet licensing criteria, or if the Contractor decides to terminate, suspend, limit, or materially change qualified service providers or subcontractors. The notice to the IDHW shall include:
  - 1. The number of Members affected by the termination, limitation, suspension, or material change decision.
  - 2. A plan to ensure that there is minimal disruption to the behavioral health Member's care and service delivery.
  - 3. The Contractor shall require the behavioral health Member's original provider to be responsible for transitioning his or her Members until the behavioral health Member has attended the first appointment with the new provider.
  - 4. A plan for clinical team meetings with the behavioral health Member and his or her family/caregiver as appropriate to discuss available options and to revise the treatment plan to address any changes in services or service providers.
  - 5. (AMENDMENT 1) A plan to communicate changes to affected Members, including provision of required notices per 42 CFR § 438.10(f)(4) and (5). The Contractor must make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) calendar days after receipt or issuance of the termination notice, to each enrollee who was seen on a regular basis by the terminated provider.
  - 6. A written transition plan for Members affected by these network changes.
- F. The Contractor shall track all Members transitioned due to a subcontract's suspension, limitation, termination, or material change to ensure service continuity. At a minimum, the Contractor shall track the following elements: name, date of birth, population type, current services the Member is receiving, services that the Member will be receiving, name of new provider, date of first appointment, and activities to re-engage persons who miss their first appointment with the new provider. The IDHW may require the Contractor to add other elements based on the particular circumstances.
- G. The Contractor shall ensure the Contractor and its providers, where applicable, use common data elements to match existing required data fields specified by the IDHW.

### XIII. Provider Training and Technical Assistance

- A. The Contractor shall develop and implement comprehensive provider training and support a training program for providers to gain and maintain appropriate knowledge, skills, and expertise and receive technical assistance to comply with the requirements resulting from this RFP. The trainings should be reported in the annual Provider Training Report. The Contractor shall incur all costs required to perform the training tasks, including facility, staffing, hardware and software cost, printing and distribution of all reports, forms, training materials, and correspondence.
- B. The Contractor shall:
  - 1. Stimulate the development of providers' capacity to treat co-occurring disorders, dual

diagnoses, very young children, Native American Members, and Hispanic Members;

2. Develop and implement training opportunities for qualified providers to occur, at minimum, once per quarter;
3. Provide technical assistance to network providers;
4. Include a cultural competency component in each training topic;
5. Educate and require providers to use evidence-based practices, promising practices, and emerging best practices;
6. Educate providers on billing and documentation requirements;
7. Provide required orientation and training for all providers new to the Contractor's network.
8. Develop and implement an annual training plan that addresses all training requirements;
9. Involvement of Members and family members in the development and delivery of trainings.

XIV. Electronic Health Records (EHR)

- A. The Contractor shall work with network providers to develop and implement EHR systems that will meet provider needs for real time data access and evaluation in medical care. See Attachment 13 - Electronic Health Records.
- B. The Contractor shall ensure that behavioral health providers participating in the managed care program adopt and use electronic health record technology. Please refer to Attachment 3 - Definitions for a definition of electronic health record and Attachment 13 - Electronic Health Records for more details regarding these requirements.

XV. Management of Care

- A. The Contractor shall provide care management and case management functions to promote achievement of the goals of this RFP including, but not limited to:
  1. Ensuring a person-centered process of care management and case management;
  2. Providing a multidisciplinary team approach that ensures working with all parties involved in the children's and adults' systems of care to establish service eligibility;
  3. Arranging for services in network including movement to higher or less restrictive levels of care;
  4. Linking to services out-of-network as appropriate;
  5. Coordinating the delivery of services including primary care services that function to rule out metabolic processes that may mimic behavioral health symptoms;
  6. Monitoring and evaluating the Member's response to the behavioral health services as well as tracking such Members with complex medical needs use of medical services;
  7. Advocating for Members who need multiple services to meet complex needs;
  8. Promoting activities and referrals to services that facilitate a Member's independence;

9. Operating a screening process for Member's seeking inpatient behavioral health services in order to activate a hospital diversion mechanism;
10. Participating in hospital discharge planning processes in an effort to impact lengths of stay and to facilitate timely admissions to step-down services;
11. Coordinating the provision of behavioral healthcare services with Medicaid's Primary Care Case Management program and with Medicaid's Health Home program to ensure the best possible outcomes for coordinated physical and behavioral health services;
12. Ensure that in the coordination of care that occurs through the Primary Care Case Management and Health Homes program confidentiality, requirements in 45 CFR parts 160 and 164 are observed; and
13. Coordinating with other providers and programs that deliver behavioral health services outside of the Contractor's delivery system.

XVI. Intake and Assessment

- A. The Contractor shall design and manage an intake process distinctive from the assessment process and that makes use of standardized tools. Currently the IDHW doesn't require a standardized tool to be used for determining Members' mental health program eligibility. The IDHW currently requires providers of substance use disorder services to use the Global Appraisal of Individual Needs (GAIN1) instruments for assessing Members seeking substance use disorders. For information on GAIN go to <http://www.chestnut.org/LI/gain/index.html>. The IDHW currently relies on a standardized tool for helping determine whether or not a child Member is experiencing a Serious Emotional Disturbance - the Child and Adolescent Functional Assessment System/Pre-school and Early Childhood Functional Assessment Scale® (CAFAS/PECFAS). For information on the CAFAS/PECFAS go to <http://www.fasoutcomes.com/>.
- B. The Contractor shall implement an intake process that includes a triage process which will identify and distinguish crises, urgent services and routine treatment needs.
- C. The Contractor shall:
  1. Ensure the intake process allows the Member to receive needed services immediately, when indicated by the presenting problem, without the delay that would be caused by the assessment process.
  2. Implement a process that results in an independent, standardized assessment of the Member's behavioral health care needs.
  3. Ensure the assessment process meets the intent of Idaho Code § 56-263.
  4. Identify and monitor episodic behavioral health needs and support intervention in a coordinated and minimally disruptive manner. Contractor's response should include screening strategies for common episodic behavioral health conditions such as affective disorders, eating disorders, adjustment disorders and coping disorders.
  5. Identify and monitor persistent behavioral health needs and support intervention in a coordinated and minimally disruptive manner. Contractor's response should include screening strategies for proactively identifying and locating persons with persistent behavioral health conditions.

XVII. Treatment Planning/Self Determination and Choice

- A. The Contractor shall implement a person-centered treatment planning process that results in improved Member and family experiences of care, promotes effectiveness and enhances outcomes. See Attachment 3 - Definitions.
- B. The Contractor shall:
  - 1. Ensure the development of a plan of care for each Member receiving behavioral health services;
  - 2. Ensure the plan of care is developed according to the Member's choices regarding his or her recovery (and in the case of dependent minors, the choices of the minor's guardian are also considered);
  - 3. Ensure the plan is derived from all available diagnostic information and all available historical and current treatment information;
  - 4. Ensure development of plans of care provides opportunities for the following to participate in the process:
    - a. All service providers affiliated with the Member;
    - b. The Member; and
    - c. All support persons the Member chooses (and in the case of dependent minors, the choices of the minor's guardian).
  - 5. Ensure the plan of care includes all the components recognized as industry standards for behavioral health treatment planning;
  - 6. Ensure an appropriate intermittent review and oversight process is utilized that is consistent with industry standards.

XVIII. Primary Care Interface: Primary Care Case Management Program (PCCM) and Health Homes

- A. The Contractor shall coordinate services with the IDHW's two (2) programs for coordination of Members' physical health needs PCCM program: Healthy Connections and a program recently developed at Medicaid: Health Homes. More information about the Healthy Connections program can be read at the following link: <http://www.healthandwelfare.idaho.gov/Medical/Medicaid/HealthyConnections/tabid/216/Default.aspx>. Please see Attachment 20 - State Medicaid Director Letters for more information about the Health Home program.
- B. The Contractor shall:
  - 1. Ensure a Member's primary care provider (PCP) has the opportunity to participate in the process used to diagnose and plan treatment for the Member;
  - 2. Ensure ongoing communication and collaboration with a Member's PCP throughout the time period that the Member receives services through the Idaho Behavioral Health Plan, including the sharing of all screenings, assessments and treatment plans;
  - 3. Ensure coordination of use of medications;
  - 4. Operate a PCP hotline, or equivalent service, for PCPs' real-time telephonic consultation with a licensed behavioral health professional at the master's level or higher for either of the following two (2) purposes:
    - a. Information to support the PCP in the provision of behavioral health interventions/services that the PCP and Member choose;

- b. Information for the PCP to use for referring the Member to the Contractor's services.
- 5. Provide on-line access to standardized screening tools for PCPs to use for identifying behavioral health issues.

XIX. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

- A. The Contractor shall recognize FQHCs that provide behavioral health services as behavioral health providers and enroll them in the Contractor's network.
- B. The Contractor shall interface with FQHC patient-centered processes to help ensure services are delivered in the most effective manner to the Members.
- C. The Contractor shall ensure that reimbursement to FQHCs and RHCs for behavioral health services done in the FQHC facility or RHC facility will be made using Medicaid's reimbursement methodology, which is payment at an encounter rate, in an amount unique to each FQHC and RHC, as determined by the IDHW.
  - 1. FQHC services are defined in IDAPA 16.03.09.832.
  - 2. RHC services are defined in IDAPA 16.03.09.820.
- D. The Contractor shall ensure that one (1) behavioral health encounter rate will be paid for all covered behavioral health services provided on the same visit to an FQHC or an RHC. Medicaid encounter rates for FQHC and RHC behavioral health providers are listed in Attachment 11 - FQHC and RHC Encounters.
  - 1. Because it is not possible to accurately project what the annual FQHC or RHC encounter rate increases may be, the IDHW will reimburse the Contractor for the difference between the encounter rates effective at the Idaho Behavioral Health Plan implementation and the FQHC or RHC rate increases over and above the annual inflation rate that may occur after the plan implementation.
- E. (AMENDMENT 1) If there are no FQHCs in the Contractor's network to choose from, then the Contractor shall pay for the access out-of-network. Should a Native American enrollee seek care from an Indian Health Program or an Urban Indian Organization owned FQHC, the Contractor shall reimburse the Indian Health Program or Urban Indian Organization owned FQHC no less than the Contractor pays any of its in-network FQHCs whether or not it is participating in the Contractor's network.

XX. Indian Health Services (IHS), Tribes and Tribal Organizations, and Urban Indian Organizations (collectively known as I/T/U) (AMENDMENT 1)

- A. The Contractor shall:
  - 1. (AMENDMENT 1) Recognize I/T/U facilities that provide behavioral health services as behavioral health providers and enroll them in the Contractor's network.
  - 2. (AMENDMENT1) Provide reimbursement for Native Americans accessing behavioral health services at I/T/U facilities. Reimbursement shall be made at the federally set encounter rate. The Contractor must reimburse I/T/U providers whether they participate in the network or not.
  - 3. (AMENDMENT 1) Report the number of encounters and the difference between the Contractor's standard reimbursement for the service and the encounter rate to the IDHW on an annual basis.

4. (AMENDMENT 1) Demonstrate there are sufficient I/T/U providers in the network to ensure timely access to services available under the contract for Native American enrollees who are eligible to receive services from such providers.
5. (AMENDMENT 1) Make prompt payment to all I/T/U providers in its network as required for payments to practitioners in individual or group practices under federal regulations at 42 CFR § 447.45 and 447.46.
6. (AMENDMENT 1) Not apply premiums or any other Medicaid cost sharing to Native American enrollees served by I/T/U providers.
7. (AMENDMENT 1) Ensure I/T/U providers receive full payment without any reduction for Medicaid cost sharing amounts.

XXI. Member Service Transitions

- A. The Contractor shall implement and monitor written policies and procedures regarding service transitions for all members.
- B. The Contractor shall demonstrate its awareness of the unique set of challenges faced by children between the ages of fourteen (14) and twenty one (21), referred to in this RFP as youth, and families when the youth transitions from the child to the adult behavioral health system. Such challenges may include application for adult Medicaid benefits, service and provider changes, lack of coordination even within a provider organization, and failure of providers to recognize the additional time, training and support necessary for youth with behavioral health disorders to achieve customary developmental milestones. Youth with serious behavioral health challenges are delayed in almost every area of psychosocial development. There may also be significant resistance to accepting the label of mental illness or a substance use disorder among youth as they approach adulthood, and accompanying resistance to engaging in treatment.
- C. The Contractor's Member Service Transition Plan shall include:
  1. How the Contractor will identify Members who need assistance and how the Members will be evaluated;
  2. At a minimum, how the Contractor will address the specialized needs of adult and youth members as noted below:
    - a. Adults:
      - i. Behavioral health Member transitions to/from another behavioral health practitioner or agency;
      - ii. Behavioral health Members whose behavioral health service provider becomes unable to continue service delivery for any reason;
      - iii. Behavioral health Member transitions to/from an assisted care facility or long term care placement for Members who continue to require behavioral health services;
      - iv. Behavioral health Member transitions from the correctional or community corrections system back to the community; and
      - v. Behavioral health Member discharges from an inpatient, sub-acute, psychiatric residential treatment facility, or mental health institute.
    - b. Youth:
      - i. Assistance with application for adult Medicaid benefits, including submitting applications in advance so that reapplication may be made, if necessary, without

losing benefits, and assisting families, as needed, to transfer diagnoses used in the child behavioral health system to the appropriate adult diagnoses;

- ii. Provide person-centered, strengths-based programming for youth from ages fourteen (14) to twenty one (21), focusing on education, employment, social and problem-solving skills, symptom management, reaction to stigma, sexual and gender identity, living situation/housing, personal health care, transportation resources, substance use disorder prevention or relapse prevention, and cultural and spiritual resources;
- iii. Provide programming to facilitate Member transitions from the juvenile correctional or community corrections system or inpatient/residential treatment back to the community;
- iv. Assist the youth and family to create a personal Safety Net of community supports, including a reliable family-like or healthy peer connection;
- v. Assess internal business practices, communication channels, and administrative support necessary to ensure a smooth transition for youth Members to the adult behavioral health system; and
- vi. Provide training and a curriculum to educate staff about the unique needs of this population.

XXII. Early Periodic Screening, Diagnosis and Treatment (EPSDT)

- A. The Contractor shall provide EPSDT benefits for Members up to the last day of the month in which they reach twenty one (21) years of age.
- B. The Contractor shall:
  - 1. Ensure Members and the network of behavioral health providers are sufficiently informed of EPSDT requirements; and
  - 2. Ensure accurate quarterly reporting of EPSDT requests, EPSDT benefits provided, EPSDT benefits denied, and the outcomes of such authorization decisions.

XXIII. Complaint, Quality of Care Concern, and Critical Incident Resolution and Tracking System

- A. (AMENDMENT 3) The Contractor shall implement and maintain a Complaint, Quality of Care Concern, and Critical Incident Resolution and Tracking System for all complaints and quality of care concerns received. For complaints, the Contractor shall have a system in place allowing providers, Members and authorized representatives of Members, the opportunity to express dissatisfaction with the general administration of the plan and services received. For quality of care concerns, the Contractor shall have a system in place allowing network providers and/or Contractor staff to document incidents of health and safety issues impacting a Member.
- B. (AMENDMENT 3) The Contractor shall have policies and procedures for resolving and tracking general complaints and quality of care concerns.
  - 1. General Complaint Process. The following must be included in the Contractor's general complaint procedures:
    - a. Complaints may be lodged by a Member, Member's authorized representative, or a provider either orally or in writing.
    - b. A person designated to conduct a reasonable investigation or inquiry into the allegations made by or on behalf of the Member or provider and shall give due

consideration and deliberation to all information and arguments submitted by or on behalf of the Member or provider.

- c. Designee shall respond in writing to each General Complaint, stating at a minimum:
  - i. A summary of the General Complaint, including a statement of the issues raised and pertinent facts determined by the investigation;
  - ii. A statement of the specific coverage or policy or procedure provisions that apply; and
  - iii. A decision or resolution of the General Complaint including a reasoned statement explaining the basis for the decision or resolution.
- 2. (AMENDMENT 3) Quality of Care Process. The following must be included in the Contractor's quality of care concern procedures:
  - a. The Contractor and its network providers shall abide by Idaho State law including those laws regarding mandatory reporting.
  - b. (AMENDMENT 3) Quality of care concerns shall be defined and reported in categories of health and safety incidents affecting a Member. Definitions shall be proposed by the Contractor and approved by the IDHW.
  - c. (AMENDMENT 3) Quality of care concerns shall be logged by the Contractor when a quality of care concern is reported, observed or noted.
  - d. (AMENDMENT 3) Designate a network provider or Contractor staff to conduct a reasonable investigation or inquiry into the quality of care concerns logged, and give due consideration and deliberation to all information submitted by or on behalf of the Members.
  - e. (AMENDMENT 3) Designee shall resolve each quality of concern report by documenting at a minimum:
    - i. (AMENDMENT 3) A summary of the quality of care concern including a statement of the issues raised and pertinent facts determined by the investigation;
    - ii. A statement of the specific coverage or policy or procedure provisions that apply; and
    - iii. (AMENDMENT 3) A decision or resolution of the quality of care concern including a reasoned statement explaining the basis for the decision or resolution.
- C. (AMENDMENT 3) The Contractor's Complaint and Quality of Care Concerns Resolution and Tracking System shall include components that allow the Contractor to analyze the complaint or quality of care concern and provide reports as requested by the IDHW.
- D. The Contractor shall:
  - 1. (AMENDMENT 3) Have a methodology for reviewing and resolving complaints and quality of care concern received including timelines for the process.
  - 2. (AMENDMENT 3) Ensure complaints and quality of care concerns are resolved within ten (10) business days. Ensure Quality of Care Concerns are resolved within thirty (30) calendar days based upon the IDHW-approved Optum Idaho QOS Complaints and QOC Concerns Policy and Procedure document.
  - 3. Ensure complainants are sent written notifications of complaint resolutions that have all of the required information.

4. (AMENDMENT 3) Address complaints and quality of care concerns that may need resolution at the IDHW level.
  5. (AMENDMENT 3) Have internal controls to monitor the operation of the complaint and quality of care concerns resolution and tracking system.
  6. (AMENDMENT 3) Track all complaints and quality of care concerns, whether they are resolved or in the process of resolution, and report the information to the IDHW.
  7. (AMENDMENT 3) Analyze complaints and quality of care concerns and utilize the information to improve business practices.
- E. (AMENDMENT 3) The Contractor shall ensure that all documents pertaining to general complaints or quality of care concern investigations and resolutions will be preserved in an orderly and accessible manner.
- F. (AMENDMENT 3) Critical Incidents. The Contractor shall have a system for identifying, reporting and addressing all alleged critical incidents involving IBHP members. The Contractor shall report critical incidents meeting high profile criteria within twenty-four (24) hours of identification:
1. (AMENDMENT 3) The Contractor shall have a system for identifying and addressing all alleged critical incidents involving IBHP members.
  2. (AMENDMENT 3) The Contractor and its network providers shall abide by Idaho state law regarding mandatory reporting.
  3. (AMENDMENT 3) Critical incidents shall be defined and reported to IDHW in categories of health and safety incidents affecting a member. Definitions shall be proposed by the Contractor and are subject to approval by the IDHW.
  4. (AMENDMENT 3) Critical incidents shall be logged by a network provider, or the Contractor itself, when a critical incident is either observed or noted.
  5. (AMENDMENT 3) The Contractor shall designate a network provider or Contractor staff to conduct a reasonable and prompt investigation or inquiry into the critical incident logged, and give due consideration and deliberation to all information submitted by or on behalf of the Members.
  6. (AMENDMENT 3) The Contractor shall take action as necessary to address all confirmed critical incidents.
  7. (AMENDMENT 3) The Contractor shall not be required to disclose to the public any information that is confidential under federal or state laws and regulations.
- G. (AMENDMENT 3) Provider Disputes. The Contractor shall implement and monitor written policies and procedures regarding the review and resolutions of provider disputes.

XXIV. Member Grievances and Tracking System

- A. The Contractor shall have a system in place for Members and a Member's authorized representative to file a Grievance challenging the Contractor's actions related to services.
- B. The Contractor shall have policies and procedures for addressing and tracking Grievances.
  1. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a licensed clinician or

physician who has appropriate clinical expertise in the treatment requested for the Member.

C. The Contractor's policies and procedures shall include:

1. Definitions:

- a. Action means the denial or limited authorization of a requested service; termination, suspension, or reduction of a previously authorized service, the denial, in whole or in part, of a payment for service; or the failure to act upon a request for services in a timely manner.
- b. Appeal means a clear expression by the Member, or the Member's authorized representative, following a decision by the Contractor, that the Member wants the opportunity to present their case to the IDHW.
- c. Grievance means an expression of dissatisfaction challenging the Contractor's action.
- d. Notice means a written statement of the action the Contractor has taken or intends to take, the reasons for the action, the Member's right to file a Grievance and request a fair hearing with the IDHW, and the procedures for exercising that right.

2. Notice of Action:

- a. The notice must be in writing and comply with the language and format requirements of 42 CFR § 438.10(c) & (d), with Spanish as the prevalent non-English language.
- b. The notice must be given to the requesting provider and to the Member.
- c. The notice must explain the following:
  - i. The action the Contractor has taken or intends to take;
  - ii. The reasons for the action including the correct citation to any applicable laws or regulations;
  - iii. The procedures for filing a Grievance with the Contractor;
  - iv. The Member's right to represent themselves or be represented by a person of their choosing; and
  - v. (AMENDMENT 3) The right to request a fair hearing upon receipt of the notice of action with the IDHW if they are not satisfied with the Contractor's resolution of the Grievance.

3. Timing of Notice:

- a. (AMENDMENT 1) For standard service authorization decisions that deny or limit services, the Contractor must give notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed fourteen (14) calendar days following receipt of the request for service as specified in 42 CFR § 438.210(d)(1);
- b. For cases in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the participant's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the participant's health condition requires and no later than three (3) business days after receipt of the request for service. The Member or provider may file an expedited appeal either orally or writing. No additional Member follow-up is required.

- c. If the Contractor extends the timeframe for decision in accordance with 42 CFR § 438.210(d)(1), it must:
    - i. Give the Member written notice of the reason for the extension of time and inform the participant of the right to file a Grievance if they disagree; and
    - ii. Issue and carry out its decision no later than the date the extension expires.
  - d. (AMENDMENT 3) For service authorization decisions not reached within the timeframes specified in 42 CFR § 438.210(d) (which constitutes a denial), the Contractor shall give notice on the date the timeframes expire.
  - e. (AMENDMENT 3) For termination, suspension, or reduction of previously authorized covered services, within the timeframes specified in 42 CFR §§ 431.211, 431.213, and 431.214 as indicated by 42 CFR §§ 431.211, a member will be mailed a notice ten (10) days before the date of an action when a previously authorized covered service is being terminated, suspended or reduced.
4. Grievance Process:
- a. A Member or Member's authorized representative may file a Grievance.
  - b. A Grievance may be filed either orally or in writing with the Contractor. If mistakenly filed with the IDHW, it will be immediately forwarded to the Contractor.
  - c. (AMENDMENT 3) Allow a reasonable time period following its action for the Member or authorized representative to file a Grievance. The Member or authorized representative has twenty-eight (28) days from the date the decision is mailed to file a Grievance.
  - d. Give Members any reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
  - e. Acknowledge receipt of each Grievance.
    - i. Ensure that individuals who make decisions on Grievances are individuals who were not involved in any previous review or decision of the action; and if deciding a Grievance of a denial based on medical necessity or involving clinical issues, are health care professionals who have the appropriate clinical expertise, as determined by the IDHW, in treating the Member's condition.
5. Grievance Decision and Notification.
- a. Notice of Grievance decisions shall be provided to the affected parties, in writing, within thirty (30) days from the date the Contractor received the Grievance stating at a minimum:
    - i. A statement of the Grievance issue(s);
    - ii. A summary of the facts asserted by each party;
    - iii. The Contractor's decision supported by a well-reasoned statement that explains how the decision was reached;
    - iv. The date of the decision; and
    - v. (AMENDMENT3) For Grievances not resolved wholly in favor of the Member, the Contractor's notice shall state the following: "If you are not satisfied with the resolution of your Grievance, you, or your representative, have the right to appeal our decision by requesting a fair hearing with the Idaho Department of Health and

Welfare. You have twenty-eight (28) days from the date of this decision to file your request. You must explain why you disagree with this decision and provide any other information you want the IDHW to know. Please include a copy of this notice. Your fair hearing request must be received by the IDHW or postmarked within twenty-eight (28) days of this notice. You can bring your request to any local Health and Welfare office, send via fax, or mail to: Administrative Procedures Section; Idaho Department of Health and Welfare; 450 W. State St., 10th Floor; P.O. Box 83720; Boise, ID 83720-0036; Fax: (208) 334-6558.

6. Miscellaneous Requirements.
  - a. Information about Grievance System. The Contractor shall provide the information specified in this section about the Grievance system to all providers and subcontractors at the time they enter into a contract.
  - b. Recordkeeping and Reporting Requirements. The Contractor shall maintain records of Grievances and must review the information as part of the State quality assurance.
  - c. (AMENDMENT 3) Effect of Reversed Decisions.
    - i. (AMENDMENT 3) Authorization of Services. If the Contractor or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the Grievance or appeal was pending, the Contractor shall authorize or provide the disputed services promptly.
    - ii. (AMENDMENT 3) If the Contractor or the State Fair Hearing officer reverses a Contractor decision to deny authorization of services, and the participant received the disputed services while the Grievance or appeal was pending, the Contractor must pay for those services, in accordance with State policy and regulations.
- D. The Contractor shall:
  1. Have a methodology for reviewing and resolving Member Grievances, including timelines for the process.
  2. Ensure internal controls to monitor the operation of a Member Grievance Tracking System.
  3. Track all Member Grievances received, whether they are resolved or in the process of resolution, and report the information to the IDHW.
  4. Analyze the Member Grievances and utilize the information to improve business requirements.

XXV. Electronic System and Data Security

- A. The Contractor shall implement and maintain an electronic system and data security plan that includes, but is not limited to all of the requirements outlined in Attachment 6 - Technical Requirements: Electronic Systems, Data Security and Website Requirements. In addition to submitting the Electronic System and Data Security Plan with the proposal, the Contractor may be required to submit a revised Electronic System and Data Security Plan for review as outlined in Attachment 10 - Readiness Review.
- B. The Contractor shall comply with the requirements in Attachment 6 - Technical Requirements: Electronic Systems, Data Security and Website Requirements; provided, however, in the event a change in MMIS vendors is required, the State and Contractor will endeavor to work in good faith to minimize the operational and financial impact of such change.

XXVI. Website

- A. The Contractor shall provide and maintain an internet website for Idaho's Medicaid Members and the network providers to access information pertaining to the Idaho Behavioral Health Plan.
  - 1. Website content regarding the Idaho Behavioral Health Plan shall be submitted to the IDHW for review and approval prior to posting the information on the website. See Attachment 6 - Technical Requirements: Electronic Systems, Data Security and Website Requirements.
- B. The Contractor shall:
  - 1. Communicate policies, procedures and relevant information to providers through secure or public Web pages.
  - 2. Provide, in accordance with national standards, claims inquiry information to qualified service providers and subcontracts via the Contractor's Website.
- C. The Contractor shall agree to the requirements in Attachment 6 - Technical Requirements: Electronic Systems, Data Security Plan and Website Requirements.

XXVII. Member Information and Member Handbook

- A. The Contractor shall provide all Members, not just those who access services, with appropriate information about behavioral treatment services, available providers, and education related to recovery, resilience and best practices.
- B. (AMENDMENT 1) The Contractor shall develop and maintain a Member Handbook for behavioral health coverage and benefits. The Member Handbook shall contain the required information per 42 CFR § 438.10(f)(6) as described in Section I.B.3 of this contract. Member Information and the Member Handbook shall be available in hard copy and through web site access at least twenty (20) calendar days prior to the start of services. The Member Handbook shall be mailed at the time of enrollment to each new Member. The Member Handbook shall be mailed no less than twice each month. The Member Handbook shall include, but not be limited to:
  - 1. Behavioral Health program eligibility process and guidelines;
  - 2. Benefit descriptions and limitations;
  - 3. Resource information including, but not limited to:
    - a. Provider directory by city;
    - b. Hospital information and resources;
    - c. Behavioral health information and resources; and
    - d. Crisis information and resources.
  - 4. Member's Rights, including the following:
    - a. Each Member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
    - b. Each Member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.
    - c. Each Member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.

- d. Each Member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
  - e. Each Member is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR § 164.
  - f. Each Member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Contractor and its providers or the IDHW treats the Member. 42 CFR § 438.100(c)
- C. The Contractor shall comply with any other applicable federal and state laws (such as Title VI of the Civil Rights Act of 1964, etc.) and any other federal and state laws that pertain to Members' rights, i.e., "Members Bill of Rights", and other laws regarding privacy and confidentiality. 42 CFR § 438.100(a)(2) and (d); 42 CFR § 438.6(f)(1).
- D. The Contractor shall obtain input from consumers, secondary Member and/or family Members and other stakeholders who can inform both the content and presentation of the information so that the information is provided in a manner and format that may be easily understood per 42 CFR § 438.10(b)(1).
- E. The Contractor shall:
- 1. Ensure that written material is in an easily understood language and format, and be provided in English and Spanish. Written material shall be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. The Contractor shall also ensure Members are aware of this availability. 42 CFR § 438.10(d)(1)(i) and (ii) and (2);
  - 2. Ensure written policies regarding the Member rights specified in this section;
  - 3. Comply with any applicable federal and state laws that pertain to Member rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to Members;
  - 4. Ensure limitations are not imposed on Members' freedom to change between mental health or Substance Use Disorder providers;
  - 5. Ensure the requirements in Attachment 8 - Member Rights are incorporated in your business operations.

#### XXVIII. Member Protections/Liability for Payment

- A. The Contractor shall implement policies to ensure no participating or non-participating provider bills a Member for all or any part of the cost of a covered, required, or optional service.
- B. The Contractor shall cover continuation of services to enrollees for the duration of the period for which payment has been made. (State Medicaid Manual 2086.6.B)
- C. The Contractor shall ensure Members are not held liable for:
  - 1. Payments, including the Contractor's debts, in the event of the Contractor's insolvency per 42 CFR § 438.106(a) and 42 CFR § 438.116(a);
  - 2. Payments in the event the state agency does not pay the Contractor, or the State or the Contractor does not pay the Member or health care provider, 42 CFR § 438.106(b);

3. The covered services provided to the Member for which the Contractor does not pay the agency or individual practitioner; 42 CFR § 438.106(b); and
4. Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount the Member would owe if the Contractor provided the service directly (i.e., no balance billing by providers). 42 CFR § 438.106(c)

XXIX. Provider Manual

- A. The Contractor shall develop and maintain a Provider Manual for use by the Contractor's network of providers.
- B. The Contractor shall ensure providers have access to the Provider Manual and any updates either through the Contractor's website, or by providing paper copies to providers who do not have Internet access. The manual shall be updated as information changes and shall include, but not be limited to:
  1. General Information:
    - a. Overview of Program
    - b. Directory
    - c. Remittance Advice Analysis
  2. References
    - a. Glossary
    - b. Billing Instructions
    - c. Resources
  3. Claims Instructions
    - a. Provider Guidelines
    - b. Service Definitions
    - c. Provider Qualifications
    - d. Provider Responsibilities
    - e. Authorization Process
    - f. Payment
- C. (AMENDMENT 3) The Contractor shall give all qualified service providers and subcontractors access to the Contractor's Provider Manual.

XXX. Community Partnerships

- A. (AMENDMENT 3) The Contractor shall operate in cooperation with the state's Behavioral Health Authority.
- B. The Contractor shall facilitate the delivery of medically necessary services in fulfillment of court ordered treatment for Members stemming from Idaho's problem-solving courts (mental health

court, drug court, veterans' court).

- C. The Contractor shall collaborate with and support the efforts of local advocacy organizations and state agencies including, but not limited to, current efforts underway to establish a sustainable community-based twenty four (24) hour suicide response system.
- D. The Contractor shall offer processes and services in support of the challenges faced by foster parents of children with SED, refugee relocation agencies, and various IDHW home visiting programs.
- E. The Contractor shall lead an ongoing collaboration with the practitioners and agencies that the Contractor enrolls in the provider network to deliver services under the Idaho Behavioral Health Plan and demonstrate how input from this group shall be incorporated into the Contractor's policies and procedures.
- F. (AMENDMENT 3) The Contractor shall support the development of a consumers' committee through the Contractor's Quality Committee Structure called the Member Advisory Committee that will serve in an advisory capacity to the Contractor which would represent the voice of Members and their families who use the services provided under the Idaho Behavioral Health Plan, and demonstrate how input from this group shall be incorporated into the Contractor's policies and procedures.
- G. The Contractor shall collaborate with Idaho's Regional Mental Health Boards. (ID Code § 39-3130), [www.healthandwelfare.idaho.gov/Medical/MentalHealth/RegionalMentalHealthBoards/tabid/332/Default.aspx](http://www.healthandwelfare.idaho.gov/Medical/MentalHealth/RegionalMentalHealthBoards/tabid/332/Default.aspx).
- H. The Contractor shall collaborate with the Substance Use Disorders Regional Advisory Committees (ID Code § 39-303A) [www.healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/RegionalAdvisoryCommittees/RACRegion4/tabid/198/Default.aspx](http://www.healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/RegionalAdvisoryCommittees/RACRegion4/tabid/198/Default.aspx). The Boards and Councils are scheduled for reorganization through statutory changes in the 2013 legislative session which is expected to combine the two (2) types in readiness for mental health services and substance use disorder services to become integrated into "behavioral health services."
- I. The Contractor shall interact and support the efforts of behavioral health advocacy groups in Idaho including but not limited to the Idaho State Planning Council on Mental Health, the Idaho chapter of National Association of Mental Illness (NAMI Idaho), and the Office of Consumer and Family Affairs.
- J. The Contractor shall interact and collaborate with the various Idaho chapters of national associations for behavioral health professionals, including but not limited to the National Association of Social Workers, American Psychological Association, American Psychiatric Association, American Counseling Association, American Association for Marriage and Family Therapists, United States Psychosocial Rehabilitation Association, the Idaho Association of Infant Mental Health, as well as the regulatory agencies, e.g., Idaho Bureau of Occupational Licensing, the Idaho Board of Nursing, the Idaho Board of Medicine, and the Idaho Board of Alcohol/Drug Counselor Certification.

XXXI. Community Reinvestment Services (Amd 1)

- A. (AMENDMENT 1) This requirement has been removed from the contract. The Section has been retained to preserve numbering for contract monitoring purposes.

XXXII. Outcomes, Quality Assessment, and Performance Improvement Program

- A. For all covered services, the Contractor shall maintain a comprehensive outcomes, quality assessment, quality management, quality assurance, and performance improvement program and includes evaluation of the Contractor's operations.
- B. Quality Improvement Plan -- The Contractor shall:
  - 1. Have, in effect, a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program.
  - 2. Ensure the assurance plan is approved by the IDHW.
  - 3. Maintain a sufficient number of qualified quality assurance personnel to comply with and implement all of the requirements of this contract in a timely manner, including:
    - a. Reviewing performance standards;
    - b. Measuring treatment outcomes;
    - c. Assuring timely access to care; and
    - d. Participating in an independent assessor's quality review activities.
  - 4. Provide a mechanism for the input and participation of Members, families, caretakers, and other stakeholders in the monitoring of service quality and determining strategies to improve outcomes.
  - 5. Ensure the scope of the outcomes, quality assessment and performance improvement program include all requirements in this section but is not limited to these requirements. These requirements include:
    - a. Processes to assess, measure, and improve the quality of care provided to Members in accordance with:
      - i. All quality assurance requirements identified in this contract;
      - ii. The IDHW's Division of Medicaid;
      - iii. All IDHW and federal regulatory requirements; and
      - iv. All other applicable documents incorporated by reference.
  - 6. Identify and resolve systems issues consistent with a continuous quality improvement approach. The Contractor shall include a Corrective Action Plan (CAP) that defines the corrective action response needed to arrive at a common solution to operations.
  - 7. Disseminate relevant information to the IDHW, Members, providers, and key stakeholders, including families and caregivers.
  - 8. Solicit feedback and recommendations from key stakeholders, subcontractors, Members, families, and caregivers, and use the feedback and recommendations to improve the quality of care and system performance.
  - 9. Measure and enforce adherence with the goals and principles of the IDHW through the following strategies, at a minimum:
    - a. Methods and processes that include in-depth chart reviews and interviews with key persons in the Member's life.
    - b. Use of findings to improve practices at the subcontractor and Contractor levels.

- c. Timely reporting of findings and improvement actions taken and their effectiveness.
  - d. Dissemination of findings and improvement actions taken and their effectiveness to key stakeholders, committees, Members, families, and caregivers, and posting on the Contractor's Website.
- C. Practice Guidelines - The Contractor shall:
  - 1. Adopt and implement practice guidelines per 42 CFR § 438.236(b) that, at a minimum meet the following requirements:
    - a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.
    - b. Consider the needs of the Members.
    - c. Are adopted in consultation with contracting health care professionals.
    - d. Are reviewed and updated periodically as appropriate.
    - e. Are approved by the IDHW.
  - 2. Meet the requirements of the federal managed care regulations, and the 42 CFR Part 2 confidentiality regulations when adopting practice guidelines.
  - 3. Ensure that decisions for Member education, coverage of services, utilization management and other areas to which the practice guidelines apply shall be consistent with the practice guidelines per 42 CFR § 438.236(d).
  - 4. Disseminate the practice guidelines to all affected providers, and upon request, to Members per 42 CFR § 438.236(c).
- D. Performance Improvement Projects - The Contractor shall:
  - 1. Have in progress a minimum of one (1) performance improvement project (PIP) and one (1) focused study with intervention or two (2) PIPs annually.
    - a. At least one (1) PIP or the focused study shall be outcome-focused.
    - b. The PIPs shall be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction.
    - c. Each PIP shall be completed in a reasonable time period, so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.
    - d. The PIPs shall involve the following:
      - i. Measurement of performance using objective quality indicators.
      - ii. Implementation of system interventions to achieve improvement in quality.
      - iii. Evaluation of the effectiveness of the interventions.
      - iv. Planning and initiation of activities for increasing or sustaining improvement.
  - 2. Summarize the status and results of each PIP in the annual quality report and when requested by the IDHW.

3. Submit the status and results of each PIP on the agreed upon schedule in sufficient detail to allow the IDHW and/or its designee to validate the projects.
  4. Ensure PIPs are validated by the IDHW's independent assessor. The primary objective of the PIP validation is to determine compliance with the following requirements:
    - a. Measurement of performance using objective valid and reliable quality indicators.
    - b. Implementation of system interventions to achieve improvement in quality.
    - c. Empirical evaluation of the effectiveness of the interventions.
    - d. Planning and initiation of activities for increasing or sustaining improvement.
  5. During the life of the contract, participate in the annual measurement and reporting of the performance measures required by the IDHW, with the expectation that this information will be placed in the public domain.
  6. Calculate additional performance measures when they are developed and required by CMS or the IDHW.
  7. Ensure the quality assurance program includes a system of performance indicators and Member and family outcome measures that address different audiences and purposes.
- E. Outcomes Assessment Process - The Contractor shall:
1. Implement and maintain a formal outcomes assessment process that is standardized, reliable, and valid in accordance with industry standards.
  2. Work with the IDHW to develop agreed-upon measurement criteria, reporting frequency and other components of this requirement.
  3. Participate in developing, implementing, and reporting on performance measures and topics for PIPs required by the IDHW or other federal agencies, including performance improvement protocols or other measures, as directed by the IDHW and shall report the outcomes of such PIPs.
  4. Measure performance indicators for the provider network, as a whole, and for each provider individually.
  5. Have policies and procedures in place that detail how the Contractor will assess the quality and appropriateness of care and services furnished to all Members enrolled under the contract.
  6. Have policies and procedures in place that explain how the Contractor will ensure that providers are assessing Members outcomes in accordance with the requirements identified this contract.
- F. Record System - The Contractor shall:
1. Establish, maintain, and use a Member record system that meets requirements at 42 CFR § 456.111 and 211 and IDAPA 16.03.09. The Member record system shall facilitate the documentation and retrieval of statistically-meaningful clinical information, as follows:
    - a. Clinical records shall be maintained in a manner that is current, detailed, and organized and that permits effective Member care and quality review;
    - b. The Contractor shall require providers to maintain records in the same manner;
    - c. Records may be written or electronic;

2. Have written policies and procedures regarding clinical records that include, at a minimum:
    - a. Content, confidentiality protections, retention, and access by Members to their individual records, which shall include the Member's right to see their individual medical records upon request during regular business hours and to copy those records for a reasonable fee, which will not exceed the actual cost of making the copies.
    - b. The processing and storage of records, disposal procedures, and retrieval and distribution.
    - c. A system to access and audit the content of clinical records to ensure that they are legible, organized, complete, and conform to its standards and that clinical records shall be made available to the IDHW immediately upon request by the IDHW.
    - d. A copy of the Contractor's policies and procedures shall be made available to the IDHW and to network providers upon request, and copies of the amendments or modifications to the policy will be promptly filed.
    - e. The Contractor and its providers shall have the ability to record and report data at the level of clinical transactions.
  3. Support Medicaid's efforts currently underway to implement the use of electronic health records as described in Attachment 13 - Electronic Health Records, including effectively interfacing with primary care practices in the Medicaid Health Home Project that are required to use electronic health records.
- G. Health Information System (HIS) in Quality Assurance Activities - The Contractor shall:
1. Maintain a health information system that collects, analyzes, integrates and reports data. Requirements for the development of a Health Information System for the provider network users are described in detail in this RFP.
  2. Ensure the system provides information on areas including, but not limited to, grievances and appeals, third party liability, for other than loss of Medicaid eligibility.
  3. Ensure the system collects data on Member and provider characteristics as specified by the IDHW and on services furnished to Members through an encounter data system.
  4. Make all collected data available to the IDHW and/or designee and upon request by CMS.
  5. Collect data and conduct data analysis with the goal of improving quality of care.
  6. Ensure the information system supports the quality assurance and program improvement process by collecting, analyzing, integrating, and reporting necessary data.
  7. Ensure that data received from providers is accurate and complete by:
    - a. Verifying the accuracy and timeliness of reported data.
    - b. Screening the data for completeness, logic, and consistency.
    - c. Collecting service information in standardized formats to the extent feasible and appropriate.
- H. Member Satisfaction - The Contractor shall:
1. Monitor Member perceptions of well-being and functional status, as well as accessibility and adequacy of services provided by the Contractor.

2. Support the IDHW's efforts to collect Member satisfaction data.
  3. Conduct an annual Member satisfaction survey as directed and prior approved by the IDHW. The results of the survey shall be disclosed to Members upon request.
  4. Use the information from the Member satisfaction survey to improve services.
- I. (AMENDMENT 3) This requirement has been moved to another portion of the contract. The section has been retained to preserve numbering for contract monitoring purposes.
  - J. Quality Assurance and Program Improvement Committee - The Contractor shall:
    1. Form a quality assurance and program improvement Committee. The Contractor's Medical Director shall provide oversight of the Committee.
    2. Include practitioners and agencies that are enrolled in the Contractor's provider network in designing the work of the quality assurance processes.
  - K. Independent Assessment - The Contractor shall:
    1. Participate in annual independent reviews performed by a IDHW approved independent assessor of quality outcomes, timeliness of, and access to, services in order to validate performance improvement projects and performance measures and to review compliance with the IDHW standards and contract requirements.
    2. Provide any information required by the independent assessor to complete the review.
  - L. Performance Measures - The Contractor shall:
    1. On an annual basis, ensure and report to the IDHW its performance, using standard measures required by the IDHW. In addition, CMS, in consultation with the IDHW's and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by the IDHW in the contract with the Contractor.
  - M. Methods of Data Analysis - The Contractor shall:
    1. Use an industry recognized methodology, such as SIX SIGMA or another method(s) for analyzing data.
    2. Demonstrate inter-rater reliability testing of evaluation and assessment decisions.
    3. Measure the effectiveness of service delivery through the use of standardized, outcome-based instruments.
  - N. Outcomes Management and Quality Improvement Plan - The Contractor shall:
    1. Develop and implement an Outcomes Management and Quality Improvement Plan. The Contractor shall participate in the review of the quality improvement findings and shall take action as directed by the IDHW. The plan shall:
      - a. Delineate future quality assessment and performance improvement activities based on the results of those activities in the annual report.
      - b. Integrate findings and opportunities for improvement identified in studies, performance outcome measurements, Member satisfaction surveys, provider satisfaction surveys, and other monitoring and quality activities.
      - c. Be subject to the IDHW and/or designee's approval.
      - d. Include, but is not limited to, the following:
        - i. Call center performance in answering calls.

- ii. Child, youth, young adult and families/caregivers satisfaction with providers.
  - iii. Reliability and timeliness of service.
  - iv. Decision-making processes.
  - v. Network adequacy.
  - vi. Attainment of positive outcomes by service line and system wide, including clinical and functional outcomes and system-wide outcomes.
- O. Provider Quality Improvement Activities - The Contractor shall:
- 1. Monitor subcontracted provider quality improvement activities to ensure compliance with federal and state laws, regulations, IDHW requirements, this Contract, and all other Quality Management (QM) requirements.
  - 2. Make records and other documentation available to the IDHW, and ensure subcontractors' participation in, and cooperation with, any QM reviews. This may include participation in staff interviews and facilitation of Member/family/caregiver and subcontractor interviews.
  - 3. Use quality management review findings to improve quality of care.
  - 4. Take action to address identified issues, as directed by the IDHW.
- P. Provider Monitoring - The Contractor shall:
- 1. Monitor and evaluate qualified service providers in order to promote improvement in the quality of care provided to Members.
  - 2. Monitor all provider agencies and individual practitioners' performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the IDHW, consistent with industry standards, federal and state laws and regulations.
  - 3. Update a provider monitoring plan in the required annual Quality Management Plan.
  - 4. In accordance with federal requirements 42 CFR § 438.206, ensure the provider monitoring plan addresses, at a minimum, the following requirements:
    - a. Maintaining and monitoring a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.
    - b. Identifying deficiencies or areas for improvement and ensuring and the provider agencies and individual practitioners shall take corrective action in the following areas:
      - i. Monitoring and reporting network turnover.
      - ii. Monitoring and reporting requests for a change in provider.
      - iii. Continually monitoring access to network services and provider capacity to maintain a sufficient number of qualified service providers, to deliver covered behavioral health services for Members, including provision of culturally informed services to persons with limited proficiency in English and those with cross-cultural treatment requirements and adapted service delivery for blind or deaf Members.
      - iv. Complying with service provider monitoring and reporting requirements in accordance with this Contract, including but not limited to a Member Access Rates Report.

- c. Demonstrating that its providers are credentialed as required by 42 CFR § 438.206(b)(6) and 42 CFR § 438.214.
- d. Ensure timely access to services:
  - i. Meeting and requiring its providers to meet IDHW standards for timely access to care and services, taking into account the urgency of the need for services per 42 CFR § 438.206(c)(1)(i);
  - ii. Ensuring that the network providers offer hours of operation that are no less than the hours of operation offered to non-Medicaid clients or comparable to Medicaid fee-for-service, if the provider serves only Medicaid Members. 42 CFR § 438.206(c)(1)(ii);
  - iii. Making services included in the Contract available twenty-four (24) hours a day, seven (7) days a week, when medically necessary. 42 CFR § 438.206(c)(1)(iii);
  - iv. Establishing mechanisms to ensure compliance by providers. 42 CFR § 438.206(c)(1)(iv);
  - v. Monitoring providers regularly to determine compliance. 42 CFR § 438.206(c)(1)(v); and
  - vi. Taking corrective action if there is a failure to comply. 42 CFR § 438.206(c)(1)(vi.)
- Q. Policies and Procedures for Managing Network - The Contractor shall:
  - 1. Uniquely identify each practitioner, allowing for the association of multiple standardized and user defined identifiers and qualifiers, including Master Provider Index (MPI), National Provider Index (NPI), Drug Enforcement Administration (DEA), and National Association of Boards of Pharmacy (NABP) identifiers.
  - 2. Provide online access to the IDHW for all historical provider related information to include:
    - a. Claims;
    - b. Prior authorizations and referrals; and
    - c. Correspondence.
  - 3. Perform data exchanges to obtain provider data from licensing boards, CMS, DEA, the NPI enumeration contractor, and other IDHW specified sources.
  - 4. (AMENDMENT 1) This requirement has been removed from the contract. The section has been retained to preserve numbering for contract monitoring purposes.
  - 5. Provide online inquiry or lookup for the IDHW for a minimum of sixty (60) months of historical provider information, searchable by entering complete or partial identifying information:
    - a. Medicaid provider identification;
    - b. Provider name;
    - c. NPI;
    - d. Medicare number;
    - e. Social security number;

- f. Phone number;
  - g. EIN/TIN;
  - h. DEA;
  - i. Type/specialty/taxonomy;
  - j. Previous identifier(s); and
  - k. Other identifiers used by the IDHW.
6. Display claims summary information, by provider, to include: month-to-date, quarter-to-date, and year to date levels that will indicate the total number of claims submitted, pending, denied, paid and the total dollar amounts of each category.
  7. Display prior authorization by provider to include: month-to-date, quarter-to-date, and year-to-date levels that will indicate the total number of prior authorizations requested, approved, pending, denied, and the total dollar amount of each category.
  8. Include provider data repository definition of provider entities to include:
    - a. Pay-to or tax entities;
    - b. Service entities including:
      - c. Licensed or certified entities providing services including physicians and all behavioral health practitioners;
      - d. Medical groups and FQHCs; and
      - e. Non-traditional providers including transportation Providers.
  9. Define provider's periods of eligibility using, at a minimum, eligibility begin and end dates and status indicator(s).
  10. Display provider eligibility information in reverse chronological order (i.e., most current information is displayed first).
  11. Affiliate one or more service provider(s) to one or more "pay to" entities.
  12. Have the ability to capture, at a minimum, provider:
    - a. Address information;
    - b. Office contact person;
    - c. Phone number;
    - d. Fax number;
    - e. Emergency contact numbers; and
    - f. Office or facility profile (content will vary based on entity type).
  13. Accommodate Idaho Bureau of Occupational Licensing (IBOL) certification information which includes:

- a. Type, specialty, and sub specialty;
  - b. Taxonomy;
  - c. Certification begin and end dates;
  - d. Certification type code;
  - e. Certifying agency;
  - f. Certifying state;
  - g. Verification date; and
  - h. Verification due date.
14. Accommodate licensing, credentialing, sanction and certification information that includes:
- a. License identification;
  - b. Certification type;
  - c. Certifying agency;
  - d. Certifying state;
  - e. Certification begin and end dates;
  - f. Verification date;
  - g. Verification due date;
  - h. Verification type;
  - i. Sanctioning agency;
  - j. Sanctioning state; and
  - k. Sanction beginning and end dates.
15. Identify and create alerts and reports of providers due for re-certification or license verification, sixty (60) days prior to the end date of the current license, certification, or provider agreement.
16. Define the relationship between a provider and an Electronic Data Interchange (EDI) submitter.
17. Define surveillance status and pend or deny for CMS-1500 claims by date parameters and other qualifiers which may include:
- a. Media type;
  - b. Healthcare Common Procedure Coding System (HCPCS) code begin and end range;
  - c. International Classification of Diseases (ICD) diagnosis code begin and end range; and
  - d. ICD procedure code beginning and end range.

18. Identify the affiliation a physician in the provider network may have with a hospital or multiple hospitals and indicate what types of privileges they have.
19. Identify the providers panel information including:
  - a. Accepting new patient indicator;
  - b. Age range;
  - c. Gender;
  - d. Authorized enrollment; and
  - e. Current enrollment.
20. Associate multiple service locations to the same provider base identifier.
21. Identify provider 'on call' information to capture 'covering for' and 'covered by' providers.
22. Indicate a Provider's financial information, at a minimum, EIN, SSN, W9, EFT bank account, 1099 information, hold payment indicators, and federal match rate.
23. Identify the individual practitioner's insurance coverage information which includes carrier, effective and end dates, dollar limits, verification date, and verification due date for the following types of coverage:
  - a. Malpractice;
  - b. Workers compensation; and
  - c. General liability.
24. Produce reports showing which practitioners or provider agencies a Member is using and each individual agency's caseload.
25. Provide an unlimited free-form text narrative at the base Provider level that:
  - a. Identifies the user, date, and time entered; and
  - b. Provides the capability to display free form narrative in chronological or reverse chronological sequence.

**XXXIII. Compliance and Monitoring (Utilization Management)**

- A. The Contractor shall have a system for conducting utilization management, program integrity and compliance reporting activities. All aspects of the system shall be focused on providing high quality, medically necessary services in accordance with contract requirements.
- B. Program - The Contractor shall:
  1. Develop, implement, and maintain a utilization management program to monitor the appropriate utilization of covered services.
  2. Comply with CMS requirements described in 42 CFR § 456.
  3. Be under the direction of an appropriately qualified clinician; appropriateness of the qualifications of the assigned clinician shall be determined by matching the clinician's scope of expertise with the material under review.

4. (AMENDMENT 3) Ensure utilization determinations are based on written criteria and guidelines developed or adopted with involvement from practicing providers and nationally recognized guidelines.
  5. Ensure the utilization management process in no way impedes timely access to services.
- C. Policies and Procedures (P&P) - Utilization Management - The Contractor shall:
1. Have P&Ps regarding the management of service utilization. UM P&Ps shall include, but are not limited to, the following:
    - a. Annual Review and Evaluation of UM Program: P&P stating how the Contractor will evaluate the effectiveness of the UM program and subsequently revise the program as necessary. This information shall be made available to the IDHW.
    - b. Criteria:
      - i. P&P regarding the development, review and modification of utilization review criteria to include the practitioners involved and documentation of the involvement.
      - ii. Criteria shall be developed for all routinely provided care and services.
      - iii. P&P shall reflect that available criteria shall be applied to all utilization review (UR) decisions and that criteria are clearly written, are objective and evidence based whenever possible, appropriate and available to providers and Members upon request.
      - iv. There shall be a statement regarding the congruence between adopted clinical guidelines and UR criteria.
      - v. P&P for applying the criteria based on individual needs and taking into account the local delivery system.
      - vi. P&P for processing requests for initial and continuing authorizations of services per 42 CFR § 438.210(b)(1).
  2. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and consult with the requesting provider when appropriate per 42 CFR § 438.210.
  3. Ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease per 42 CFR § 438.210(b)(3).
    - a. Monitoring Over- and Under-Utilization:
      - i. P&P stating that prior authorization shall be conducted for identified levels of care.
      - ii. P&P outlining the activities undertaken to specifically identify and address under-utilization as well as over-utilization.
      - iii. At a minimum, the P&P shall include routine trending and analysis of data on levels of care (including care not prior authorized) and by provider.
      - iv. P&P providing for peer review of quality of care concerns.
    - b. Utilization Review (UR) Decisions:
      - i. Evidence, available to the IDHW upon request, of formal staff training designed to improve the quality of UR decisions.

- ii. P&P to evaluate and improve the consistency with which UR staff apply criteria (inter-rater reliability) across multiple levels of care.
    - iii. P&Ps and job descriptions to specify the qualifications of personnel responsible for each level of UR decision making (e.g., review, potential denial).
    - iv. P&P to ensure that a practitioner with appropriate clinical experience in treating the Member's condition reviews any potential denial based on medical necessity.
  - c. Timeframes:
    - i. P&Ps to address the timeliness of UR decisions made on the basis of medical necessity.
    - ii. P&Ps to address the timeframes for which prior authorization, concurrent and retrospective reviews decisions are made.
    - iii. P&Ps to address the timeliness of expedited reviews.
    - iv. P&Ps to assess the adherence to the timeframes in items i-iii.
  - d. Data and Communication:
    - i. P&P that specifies how Members and practitioners can access UM staff to discuss UM issues and decisions. This information shall be made available to Members and providers.
    - ii. P&P that describes how the organization will notify the providers and Members of UM decisions.
  - e. Obtaining Clinical Information:
    - i. P&P to obtain relevant clinical information and the circumstances under which the Contractor will consult with the treating providers when making a determination of medical necessity.
    - ii. P&P describing the decision-making process that identifies information needed to support UR decision making.
    - iii. P&P describing the process for obtaining any missing clinical information.
  - f. Other:
    - i. P&P to evaluate new technology and new applications of existing technology, to include behavioral health procedures.
    - ii. P&P to ensure any Contractor centralized triage and referral functions for behavioral health services are appropriately implemented, monitored, and professionally managed.
    - iii. P&P describing how practitioners are given information on the process to obtain the UR criteria.
- D. Documentation - The Contractor shall:
  - 1. Maintain documentation that supports the activities described in the UM program and UM policies and procedures. The Contractor shall report service utilization by type of service to the IDHW on a monthly basis.
  - 2. Ensure supporting documentation includes, but is not limited to, committee meeting

minutes, job descriptions, signatures on related materials and utilization review notes.

3. Ensure the UM program description is written so that staff members and others can understand the program. The program description shall include, but not be limited to:
  - a. Program goals;
  - b. Program structure, scope, processes and information sources, including the identification of all intensive levels of care;
  - c. Roles and responsibilities;
  - d. Evidence of Medical Director leadership in key aspects of the UM program to include denial decisions and criteria development;
  - e. A description of how oversight of any delegated UM function will occur;
  - f. A description of how staff making Utilization Review (UR) decisions will be supervised;
  - g. A statement regarding staff availability at least eight (8) hours a day during normal business hours for inbound calls regarding UM issues;
  - h. The mechanisms that will be used to ensure that Members receive equitable access to care and service across the provider network; and
  - i. The mechanisms that will be used to ensure that the services authorized are sufficient in amount, duration, or scope and can reasonably be expected to achieve the purposes for which the services are furnished.
- E. Accountability - The Contractor shall:
  1. Remain accountable for and have appropriate structures and mechanisms in place to oversee activities that are delegated to a subcontractor per 42 CFR § 438.230(a) and (b)(1), (2), (3), including a way to verify services were actually provided as required by 42 CFR§ 455.1(a)(2). This will include a written delegation agreement. The following items apply to sub-contracted activities and do not reflect the total requirements for any delegated subcontract or agreement. The Contractor shall have the following in place:
    - a. A written Delegation Agreement that includes:
      - i. A description of the responsibilities of the Contractor and the delegated entity as it relates to delegated activities;
      - ii. A description of the delegated activities;
      - iii. A description of reporting responsibilities;
      - iv. A statement that the subcontractor will comply with the standards specified in the contract between the Contractor and the IDHW for any responsibilities delegated to the subcontractor;
      - v. A description of the processes for ongoing monitoring (i.e., continuous quarterly reporting) and at least an annual formal review; and
      - vi. A description of the remedies available to the Contractor if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement and corrective action.
    - b. Oversight P&Ps:
      - i. A P&P describing the oversight (ongoing monitoring) activities that will be done

(e.g., required reporting and report frequency, activities conducted by the Contractor in reviewing the required reports, actions that will be taken depending on the review). a) The procedure shall include who reviews the reports, whether or not a committee approval is required, etc. b) The scope of oversight activities shall include all delegated UR/UM functions. c) P&P describing the formal review, which shall occur no less than annually, and at a minimum include a visit to the organization, and a document or record review.

- c. P&P describing how the quality (application of criteria, denial decisions, inter-rater reliability, etc.) of contracted services will be monitored and assessed.

F. Guidelines - The Contractor shall:

1. (AMENDMENT 1) Develop or adopt Utilization Management Guidelines to interpret the medical necessity of behavioral health services provided to Members. Medical necessity is defined in IDAPA 16.03.09 and included in Section I.B.7 of this contract. The IDHW shall be the final authority regarding all disputed medical necessity decisions.
2. Ensure the guidelines for interpreting medical necessity shall:
  - a. Be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
  - b. Consider the needs of the Members;
  - c. Be adopted in consultation with contracting health care professionals, and
  - d. Be reviewed and updated periodically as appropriate.
3. Disseminate the guidelines to all providers and, upon request, to Members.
4. In the development and implementation of Utilization Management Guidelines, include policies and procedures which recognize the need for long-term services for some Members and the need for some Members to access several services concurrently. These needs shall be recognized for both children and adults.
5. Ensure all guidelines developed by the Contractor and any modifications made to the guidelines are approved by the IDHW and shared with providers at least thirty (30) calendar days prior to implementation of the guidelines.
6. Ensure that contracted providers use the required criteria for determination of level of service, even when authorization from Contractor is not required.
7. Ensure that decisions for utilization management, Member education, coverage of services, and other areas to which the guidelines apply shall be consistent with the guidelines.
8. Limit payment to only those services that the Contractor has authorized under the guidelines which the Contractor has developed and the IDHW has approved. Any denial of payment for services funded through the Medicaid capitation payment is subject to appeal to the IDHW pursuant to standards in both state administrative rules and the State Plan or waiver.
9. Provide a forum to receive practitioner suggestions for UM Guideline revisions at least annually, and shall document all changes made subsequent to practitioner input.

G. Health Information System (HIS) in Utilization Management - Currently the IDHW's Division of Medicaid does not require mental health providers to operate any uniform HIS. The IDHW's

Division of Behavioral Health operates the WITS system which is described in greater detail in Attachment 16 - Web Infrastructures for Treatment Services (WITS). The network of substance use disorder providers currently uses this system. The Contractor shall maintain a health information system that:

1. Supports WITS or at the very least, uses a system that shall interface with WITS.
  2. Supports the utilization management process by collecting, analyzing, integrating, and reporting necessary data.
  3. Provides information on the utilization of services.
  4. Collects data on Member and provider characteristics as specified by the IDHW and on services furnished to Members through an encounter data system.
  5. Makes all collected data available to the IDHW and/or designee and upon request by CMS.
  6. Ensures that data received from providers is accurate and complete by:
    - a. Verifying the accuracy and timeliness of reported data.
    - b. Screening the data for completeness, logic, and consistency.
    - c. Collecting service information in standardized formats to the extent feasible and appropriate.
  7. Conducts comparative analysis such as the Health and Effectiveness Data and Information Set (HEDIS).
- H. Compliance and Management - The Contractor shall:
1. (AMENDMENT 3) Have a mandatory compliance plan and administrative and management arrangements or procedures designed to prevent, detect and recover overpayments from fraud, abuse and misuse of Medicaid funds and resources.
  2. Diligently safeguard against the potential for, and promptly investigate reports of, suspected fraud and abuse by employees, subcontractors, providers, and others with whom the Contractor does business by having controls in place to detect fraud and abuse, including technology to identify aberrant billing patterns, claims edits, post processing review of claims and records reviews.
  3. Provide the IDHW with the Contractor's policies and procedures on handling fraud and abuse including responding to IDHW requests for records and documentation of any sort such as provider agreements and all written and telephonic communications with a provider per the terms of the contract.
  4. (AMENDMENT 3) Report possible instances of Medicaid fraud, waste and abuse within contractual timeframes. This information shall also be reported in the quarterly Surveillance Activities Report.
  5. Describe how frequently, and by what method, it shall assure that providers' CPT billing accurately reflects the level of services provided to Members so that there is no intentional or unintentional up-coding or miscoding of services.
  6. Have in place a method to verify whether services reimbursed by the Contractor were actually furnished to eligible Members as billed by providers.
  7. Provide the IDHW with a quarterly update of surveillance activity, including corrective actions taken. This information should be reported in the Surveillance Report.

8. Have administrative and management arrangements or procedures, and a mandatory compliance plan that are designed to guard against fraud and abuse and include the following:
  - a. Written policies, procedures, and standards of conduct consistent with all applicable federal and state laws pertaining to fraud and abuse;
  - b. The designation of a compliance officer and a compliance committee that are accountable to senior management;
  - c. Effective training and education for the compliance officer and the staff;
  - d. Effective lines of communication between the compliance officer and staff;
  - e. Enforcement of standards through well-publicized disciplinary guidelines;
  - f. Provision for internal monitoring and auditing, including inspection and audit of financial records per 42 CFR § 438.6(g);
  - g. (AMENDMENT 3) Provisions for prompt response to detected offenses, recoupment of inappropriate payments, and for development of corrective action initiatives relating to the contract services;
  - h. Written procedures in place to suspend payment in accordance with Affordable Care Act provisions, Section 6402(h)(2), as well as IDAPA 16.05.07, The Investigation and Enforcement of Fraud, Abuse, and Misconduct;
  - i. (AMENDMENT 3) Responsibility to not enter into agreements with providers who have been terminated or have outstanding debts. Responsibility to terminate the provider agreement and notify the Medicaid Program Integrity Unit and the IDHW Contract Manager when providers with current agreements are added to the Idaho Medicaid Provider Outstanding Debt/Termination List;
  - j. Provision of a comprehensive written Work Plan which shall include timelines for formal communications and trainings to the provider network, no less than annually, on topics of fraud and abuse, including the Medicaid Program Integrity Unit's contact information. The trainings need to be reported in the annual Provider Training Report; and
  - k. (AMENDMENT 3) Reporting receipt of any complaints of fraud or abuse from any sources to the Medicaid Program Integrity Unit. Additionally, any information obtained regarding the abuse or exploitation of adults shall be reported to the Medicaid Program Integrity Unit in the same manner.
- I. (AMENDMENT 3) Fraud, Waste, Abuse - The Contractor shall:
  1. (AMENDMENT 3) Cooperate with all appropriate state and federal agencies, including Idaho's Medicaid Program Integrity Unit, Medicaid Fraud Control Unit and the Department of Health and Human Services Office of Inspector General in investigating fraud and abuse.
  2. (AMENDMENT 3) Comply with all federal and state requirements regarding fraud, waste and abuse, including but not limited to IDAPA 16.05.07 and Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.
  3. Submit, quarterly, a Surveillance Report to the IDHW detailing all incidents of fraud, waste and abuse detected, reported to, reviewed or investigated by the Contractor. The report

shall, at a minimum, provide:

- a. The current status and resolution of all fraud, waste, and abuse incidents detected or referred to the Contractor including the name and identification number, sources of complaint, type of provider, nature of complaint, approximate dollars involved and legal and administrative disposition of the case;
  - b. The number of provider reviews opened, pending, and completed for the current quarter, year to date, and averages per quarter;
  - c. Fraud and/or abuse issues identified;
  - d. Overpayment amounts identified in the quarter, contract to date, and average amount per quarter;
  - e. Means by which overpayments were identified;
  - f. Actions taken;
  - g. Recoupment amount collected in the previous quarter, contract to date, and average amount per quarter;
  - h. Any provider education that the Contractor delivered;
  - i. Number of cases before the IDHW awaiting approval;
  - j. Number of cases recommended for referral to Bureau of Audits and Investigations and the Medicaid Fraud Control Unit (MFCU);
  - k. Number of provider appeals filed;
  - l. Case status of appeals; and
  - m. Discussion that may include, but is not limited to, problems encountered, provider specific or statewide trends noted, and regulation revisions needed.
  - n. In partnering with the Medicaid Program Integrity Unit the Contractor shall make available to the IDHW within five (5) business days upon request:
    - i. Copies of individual provider contracts
    - ii. Copies of prior authorizations
    - iii. All written communication between the Contractor and a specified provider.
4. Furnish the IDHW, the Secretary of the U.S. Department of Health and Human Services (DHHS), or the IDHW's Idaho Medicaid Fraud Control Unit (MFCU) with such information as it may request regarding payments claimed for services provided.
  5. Grant the IDHW, DHHS and/or MFCU access during the Contractor's or subcontractor's regular business hours to examine health service and financial records related to a health service billed to a program. The IDHW will:
    - a. Notify the Contractor or subcontractor before obtaining access to a health service or financial record, unless the Contractor or subcontractor waives notice.
    - b. Access records in accordance with 45 CFR § 160-164.
    - c. Send a monthly Excel file to the Contractor of any providers that have had payment

suspended or have been terminated by CMS.

J. Compliance Program Plan - The Contractor shall:

1. Submit, annually for approval, its Compliance Program Plan.
2. Submit, within forty five (45) calendar days of the effective date of this contract, a copy of the written policies identified in the Program Integrity section of the base contract detailing compliance with:
  - a. The False Claims Act, 31 USC § 3729, et seq.;
  - b. Administrative remedies for false claims and statements;
  - c. State laws relating to civil or criminal penalties and statements;
  - d. State laws relating to civil or criminal penalties for false claims and statements; and
  - e. Whistleblower protections under such laws.
3. (AMENDMENT 3) Submit, annually, within thirty (30) business days of the IDHW's notification letter, written assurance of compliance with the False Claims Act to the IDHW's Medicaid Program Integrity Unit.
4. Not knowingly have a relationship with the following per 42 CFR § 438.610(a) and (b):
  - a. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under presidential Executive Order No. 12549 or under guidelines implementing presidential Executive Order No. 12549; or
  - b. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1) of the regulation.
  - c. For the purposes of this section, "Relationship" is defined as follows:
    - i. A director, officer, or partner of the Contractor;
    - ii. A person with beneficial ownership of five percent (5%) or more of the Contractor's equity; or
    - iii. A person with an employment, consulting or other arrangement with the Contractor under its contract with the IDHW.
5. Notify the IDHW of any person or corporation that has five percent (5%) or more ownership or controlling interest in the Contractor.
6. Not expend Medicaid funds for providers excluded by Medicare, Medicaid, or SCHIP.

K. Unique Identifier -- The Contractor shall require each individually contracted provider to have a unique identifier.

L. Encounter Data - The Contractor shall:

1. Submit encounter data to the IDHW and/or its designee on all State Plan services. The Contractor shall submit data certifications for all data utilized for the purposes of rate setting. 42 CFR § 438.604 and 438.606
2. Ensure data certification includes certification that data submitted is accurate, complete and truthful, and that all "paid" encounters are for covered services provided to or for

enrolled Members.

3. Ensure data submission complies with the federal confidentiality requirements of 42 CFR Part 2, and may require the development of Qualified Service Organization Agreements (QSOA).
4. Submit encounter claims data to the IDHW for submittal to the Medicaid Management Information System (MMIS) on a monthly basis, no later than thirty (30) calendar days following the data collection month.
5. In addition, submit encounter data to the IDHW on a quarterly basis in a flat data file format. These files are due no later than sixty (60) calendar days following the data collection quarter. The IDHW reserves the right to change format requirements at any time, following consultation with the Contractor and retains the right to make the final decision regarding format submission requirements.

M. Record-Keeping - The Contractor shall:

1. (AMENDMENT 1) Maintain records in accordance with requirements at 45 CFR § 74.53 (a) and (b):
  - a. Books, records, documents, and other evidence (hereinafter referred to as records) documenting the costs and expenses of the contract to the extent and in such detail as will properly reflect all net costs (direct and indirect) of labor, materials, equipment, supplies, services, etc., for which payment is made under the contract.
  - b. All medical records pertaining to treatment services and supports provided under the contract.
  - c. All records for the duration of the contract period and for six (6) years after the date the final payment is made to the Contractor or for the duration of contested case proceedings, whichever is longer.
2. At the contract conclusion, turn over a copy or the originals of all records to the IDHW or a party designated by the IDHW.
3. Transfer medical records to a new Contractor upon request of the IDHW.

N. Access - The Contractor shall:

1. Permit any authorized representative of the State of Idaho or the Comptroller General of the United States, or any other authorized representative of the United States Government, to access and examine, audit, excerpt, and transcribe any directly pertinent books, documents, papers, electronic, or optically stored and created records, or other records of the Contractor relating to the contract, wherever such records may be located in accordance with 42 CFR § 438.6(g). The Contractor shall permit any authorized representative of the State of Idaho or the Comptroller General of the United States, or any other authorized representative of the United States Government to evaluate through inspection or other means, the quality, appropriateness and timeliness of services performed under the contract per 42 CFR § 434.6(a)(5). The Contractor shall not impose a charge for audit or examination of the Contractor's records.
2. Provide to the IDHW upon request, all written program records including, but not limited to, statistical information, board and other administrative records, and financial records, including budget, accounting activities, financial statements, and the annual audit.
3. Ensure subcontractors comply with all of the requirements of this section for all records related to the performance of the contract.

XXXIV. Annual Network Development and Management Plan

- A. (AMENDMENT 3) The Contractor shall submit to the IDHW an annual Network Development and Management Plan, which contains specific action steps and measurable outcomes that are aligned with the IDHW provider network requirements. The Network Development and Management Plan shall take into account regional needs and incorporate region-wide, network-specific goals and objectives developed in collaboration with the IDHW. At a minimum, the analysis shall be derived from:
1. (AMENDMENT 3) Quantitative data, including performance on appointment standards/appointment availability, eligibility/enrollment data, the network inventory, and demographic (age/gender/race /ethnicity) data.
  2. Qualitative data (including outcomes data), when available; grievance information; concerns reported by Members; grievance, appeals, and request for hearings data; behavioral health Member satisfaction survey results, and prevalent diagnoses.
  3. Status of provider network issues within the prior year that were significant or required corrective action by the IDHW including findings from the Contractor's annual administrative review work.
  4. A summary of network development and management activities conducted during the prior year which includes efforts for developing providers outside the agency/clinic model.
  5. Plans to correct any current material network gaps and barriers to network development.
  6. Priority areas for network development and management activities for the following year, goals, action steps, timelines, performance targets, and measurement methodologies for addressing the priorities.
  7. The participation of stakeholders in the annual network planning process.
    - a. The Contractor's Work Plan shall be approved by the IDHW.
    - b. The Contractor shall submit progress reports as requested by the IDHW.

XXXV. Data Tracking and Utilization Information System

- A. The Contractor shall provide a Data Tracking and Utilization Information System to collect and compile data, analyze the data, generate both electronic and hard copy reports in an Excel format, and store, maintain and manage data as required in this RFP, and outlined in Attachment 6 - Technical Requirements.
- B. The Contractor shall be responsible for all programming functions and costs associated with the use and maintenance of the system.
- C. The Contractor shall adhere to the timelines established in Attachment 9 - Initial Deliverables, and Attachment 10 - Readiness Review.
1. The Data Tracking and Utilization Information System shall be fully operational within one hundred twenty (120) calendar days of the effective date of the contract.
- D. The Contractor shall:
1. Ensure system is functional and accessible to allow the IDHW to retrieve reports via Secure File Transfer Protocol (SFTP) from the Contractor.
  2. Ensure all of the required data elements identified in the Scope of Work and Reports section are included into the Data Tracking and Utilization Information System.

XXXVI. Disaster Recovery Plan

- A. The Contractor shall provide and maintain a comprehensive Disaster Recovery Plan that identifies how the Contractor will manage services in the event of a catastrophe (disaster, emergency, flooding, power failure, weather conditions, loss of phone systems, etc.).
  - 1. The Disaster Recovery Plan shall include, but is not limited to, how the Contractor will notify the IDHW when the Contractor's site requires the implementation of the Disaster Recovery Plan, how the Contractor will work with IDHW and Behavioral Health network providers and Members if a catastrophe occurs in Idaho, how services will continue with minimal disruption, how data will be safeguarded and accessible, and how Members will continue to receive behavioral health services.
- B. The Contractor may be required to submit a revised Disaster Recovery Plan for review as outlined in Attachment 10 - Readiness Review.
- C. The Contractor shall have a detailed description of their back-up plan and system to ensure that, in the event of a power failure or outage, the following are in place and functioning:
  - 1. A back-up system capable of operating the telephone system for the entire time the main system is inoperative, at full capacity, with no interruption of data collection;
  - 2. A notification plan that ensures the IDHW is notified when the Contractor's phone system is inoperative or a back-up system is being utilized; and
  - 3. Manual back-up procedure for processing requests if the system is down.
- D. The Contractor shall:
  - 1. Maintain business continuity in the occurrence of unforeseeable events impacting business operations.
  - 2. Maintain and update the Disaster Recovery Plan.
  - 3. Implement the Disaster Recovery Plan in the event of a catastrophe impacting the Contractor's site.
  - 4. Implement the Disaster Recovery Plan in the event of a catastrophe in Idaho.
  - 5. Ensure Members continue to receive behavioral health services with minimal interruption.
  - 6. Ensure data is safeguarded and accessible.
  - 7. Train staff and network providers to the requirements of the Disaster Recovery Plan to ensure all systems remain intact and all files and data are restored within twenty four (24) hours in the event of a disaster.

XXXVII. Reports/Records/Documentation

- A. The Contractor shall provide reports as outlined in Appendix C - Reports. Reports shall include data current through the respective reporting timeframe and shall be submitted within the required timeframes.
- B. The Contractor shall:
  - 1. Comply with all reporting requirements.
  - 2. (AMENDMENT 3) Ensure reports are accurate and available within the required timelines

no later than the fifteenth (15th) business day of the month.

3. Ensure copies of complete and valid provider insurance certificates are maintained for each qualified network provider and make them available to the IDHW upon request.

XXXVIII. Contract Transition Plan

- A. The Contractor shall provide and maintain a Contract Transition Plan that complies with the requirements of the contract. The objectives of the Contract Transition Plan are to minimize disruption of services provided to the IDHW and to provide for an orderly and controlled transition of the Contractor's responsibilities to a successor at the conclusion of the contract period or for any other reason the Contractor cannot complete the responsibilities of the contract. The Contractor shall submit their Contract Transition Plan as outlined in Attachment 10 - Readiness Review. In addition, the Contractor shall submit an updated Contract Transition Plan to the IDHW within one-hundred-eighty (180) calendar days prior to the conclusion of the contract.
- B. The Contract Transition Plan shall include, but not be limited to:
  1. A realistic schedule and timeline to hand-off responsibilities to the replacement contractor or the IDHW.
  2. The staff that shall be utilized during the hand-off of duties and their responsibilities such that there shall be clear lines of responsibility between the Contractor, the replacement contractor and the IDHW.
  3. The actions that shall be taken by the Contractor to cooperate with the replacement Contractor and the IDHW to ensure a smooth and timely transition.
  4. A plan on how to best inform and keep the Contractor's employees informed during the transition process.
  5. A matrix listing each transition task, the functional unit and the person, agency or Contractor responsible for the task, the start and deadline dates to complete the planned tasks, and a place to record completion of the tasks.
  6. All information necessary for reimbursement of outstanding claims.
- C. The Contractor shall:
  1. Cooperate with the IDHW during the planning and transition of contract responsibilities from the Contractor to a replacement contractor or the IDHW including, but not limited to, sharing and transferring behavioral health Member information and records, as required by the IDHW;
  2. Ensure that Member services are not interrupted or delayed during the remainder of the contract and the contract transition planning by all parties shall be cognizant of this obligation. The Contractor shall:
    - a. Make provisions for continuing all management and administrative services and the provision of services to Members until the transition of all Members is completed and all other requirements of this contract are satisfied.
    - b. Designate a transition coordinator who shall interact closely with the IDHW and the staff from the new contractor to ensure a safe and orderly transition, and shall participate in all transition meetings.
    - c. Provide all reports set forth in this contract and necessary for the transition process in Excel or another format accepted by the IDHW.

- d. Notify providers, subcontractors and Members of the contract termination, as directed by the IDHW, including transfer of provider network participation to the IDHW or its designee. The IDHW shall have final approval of all communications regarding the transition/termination of the contract.
  - e. Complete payment of all outstanding obligations for covered services rendered to Members. The Contractor shall cover continuation of services to Members for the duration of the period for which payment has been made as well as for inpatient admissions up until discharge.
3. Participate on a contract transition planning team as established by the IDHW. The Contractor's contract transition planning team shall include program evaluation staff and program monitoring staff, as well as staff that supports all automated and computerized systems and databases.
  4. Complete all work in progress and all tasks called for by the plan for transition prior to final payment to the Contractor. If it is not possible to resolve all issues during the end-of-contract transition period, the Contractor shall list all unidentified or held items that could not be resolved, including reasons why they could not be resolved, prior to termination of the contract and provide an inventory of open items along with all supporting documentation. To the extent there are unresolved items, the cost to complete these items will be deducted from the final payment. The Contractor shall specify a process to brief the IDHW or replacement contractor on issues before the hand-off of responsibilities.
  5. Notify the IDHW Contract Manager within forty eight (48) hours when issues that could impact the transition process are identified. The notice shall be submitted in writing and include detailed information regarding issues/problems identified and corrective actions taken regarding the plan for transition.
  6. Stop all work as of the contract expiration date or effective date contained in the Notice of Termination. The Contractor shall immediately notify all management subcontractors, in writing, to stop all work as of the contract expiration date or the effective date of the Notice of Termination. Upon receipt of the Notice of Termination, and until the effective date of the Notice of Termination, the Contractor shall perform work consistent with the requirements of this contract and in accordance with the written Contract Transition Plan approved by the IDHW for the orderly transition of Members to another contractor or the IDHW.
  7. Unless otherwise directed by the IDHW, the Contractor shall direct subcontracted providers to continue to provide services consistent with the Member's treatment plan or plan of care.
  8. Transfer all required telephone numbers associated with the toll-free call center line telephone number(s) to the IDHW or the successor contractor, as directed by the IDHW to allow for the continuous use of the number of Member services and providers.
  9. Supply all information necessary for reimbursement of outstanding claims.

XXXIX. Quality Assurance Withhold and Incentive for Stabilization and Reduction of Behavioral Health Inpatient Costs (Amd 3)

- A. (AMENDMENT 3) The Contractor shall provide an array of outpatient services designed to prevent or limit the need for inpatient services. An initial withhold from the capitation rate for the non-dual population of five percent (5%) will be used as a quality assurance withhold. Six (6) months after the first year the Contractor has begun administering services, the IDHW will calculate the previous year expenditures and the prior year fee-for-service expenditures. The

amounts are calculated on a PMPM basis.

- B. (AMENDMENT 3) If Medicaid does not experience an increase in behavioral health inpatient expenditures above its historical trend rate of five percent (5%), the total amount of the withheld amount will be paid to the Contractor. Should Medicaid experience an increase in inpatient costs in an amount greater than its anticipated trend rate of five percent (5%), the amount of the increase above the trend rate will be subtracted from the amount withheld from the PMPM on a dollar to dollar basis, up to the total of the withheld amount. Any remaining funds are then paid to the Contractor, to be added pro-rata (2/12ths of previous period and 10/12ths of the latest period in order to align with the state fiscal year) to the Annual Benefits Expense Report, in order to determine the amount of the quality assurance withhold to be designated as Community Health Initiatives.
- C. (AMENDMENT 3) Additionally, should the IDHW experience a five percent (5%) or greater reduction in behavioral health inpatient costs, fifty percent (50%) of the savings realized will be paid to the Contractor. The calculations will occur on an annual basis throughout the life of the contract with the comparison period being the initial inpatient fee for service expenditures (09/2012-08/2013). The incentive payment for reduction of inpatient costs is capped at five percent (5%) of the net PMPM (the proposed PMPM less the five percent (5%) withhold). The incentive payment is not subject to the fifteen percent (15%) PMPM Administrative Cost limitation described in the Cost/Billing Procedure section. Both the net and total PMPM must be certified by the IDHW's actuary as actuarially sound rates. All payments, including withhold and incentive payments, must be actuarially sound as required by 42 CFR 438.6.

XL. Annual Benefits Expense Reporting and Community Health Initiatives Reserve (Amd 3)

A. Community Health Initiatives (CHI) Reserve Account

- 1. The Contractor shall set up an account with a financial institution. This account will be known as the CHI Reserve Account (CHIRA).
- 2. In the event the Contractor spends less than eighty-five percent (85%) of premium revenue on claims and quality improvement activities and fraud prevention in a state fiscal year, the difference between the Contractor's claims and quality improvement expenses and fraud prevention activity and eighty-five percent (85%) of premium revenue shall be placed into the CHIRA.
- 3. The calculation of the MLR is the sum of the Contractor's incurred claims; and expenditures on activities that improve health care quality; and fraud prevention activities (limited to zero point five percent (0.5%) of the Contractor's premium revenues); divided by adjusted premium revenue collected.
- 4. The Annual Benefits Expense Report is due to IDHW six (6) months following the end of each state fiscal year. This report is an accounting for the outpatient PMPM capitation payments received and claims, quality improvement and fraud prevention expenses. The positive difference between the Contractor's claims and quality improvement and fraud prevention expenses subtracted from eighty-five percent (85%) of premium revenue shall be placed into the CHIRA, within thirty (30) days of submittal of the report.
- 5. The Annual Benefits Expense Report will be refreshed nine (9) months after each state fiscal year end. If the quality assurance withhold is determined and deemed payable by IDHW in accordance with section XXXIX, the Contractor shall add any quality assurance withhold revenue earned that relates to the state fiscal year and will also update the claims and quality improvement costs to the Annual Benefits Expense Report.
- 6. Funds from the CHIRA may be used to cover claims and quality improvement expenses exceeding eighty-five percent (85%) of premium revenue incurred in subsequent state

fiscal years.

7. Any funds remaining in the CHIRA six (6) months after the contract ends shall be returned to IDHW or delivered to the succeeding contractor, at IDHW's option.

## Cost/Billing Procedure Amendment 3

### Cost:

The is a FIRM FIXED FEE, INDEFINITE QUANTITY contract for services specified in the Scope of Work and Attachment 6 -Technical Requirements.

The Department will pay the Contractor up to the total sum of **FIVE HUNDRED FIFTY-EIGHT MILLION EIGHT HUNDRED THIRTY-EIGHT THOUSAND SEVEN HUNDRED SIXTY-EIGHT DOLLARS AND EIGHTY-EIGHT CENTS (\$558,838,768.88)** for services satisfactorily performed and authorized under the contract as defined in the cost matrix below plus any incentives related to Scope of Work XXXIX.C.

The PMPM proposed cost, which includes administrative costs, is effective for the first four (4) years of the contract. The IDHW will conduct actuarial analyses after the first four (4) years of the contract. The IDHW shall have the option to renew the contract for two (2) additional two (2) year periods.

### COST MATRIX

Item	PMPM Services Cost	PMPM Administrative Cost (must not exceed 15% of fixed claims allowance fee)	Total PMPM cost
Idaho Behavioral Health Plan: Dual	\$98.84	\$8.35	\$107.19

Item	PMPM Services Cost	PMPM Administrative Cost (must not exceed 15% of fixed claims allowance fee)	Total PMPM cost
Idaho Behavioral Health Plan: Non-Duals	\$34.58	\$5.01	\$39.59

Original Contract	\$300,321,549.90
Amendment 1	\$0.00
Amendment 2	\$ 72,248,450.10
Amendment 3	\$186,268,768.88
<b>Total Contract Amount</b>	<b>\$558,838,768.88</b>

(AMENDMENT 3) Quality Assurance Withhold and Incentive for Stabilization and Reduction of Behavioral Health Inpatient Costs:

(AMENDMENT 3) The Contractor shall provide an array of outpatient services designed to prevent or limit the need for inpatient services. An initial withhold from the capitation rate for the non-dual population of five percent (5%) will be used as a quality assurance withhold. Six (6) months after the first year the Contractor has begun administering services, the IDHW will calculate the previous year expenditures and the prior year fee-for-service expenditures. The amounts are calculated on a PMPM basis.

(AMENDMENT 3) If Medicaid does not experience an increase in behavioral health inpatient expenditures above its' historical trend rate of five percent (5%), the total amount of the withheld amount will be paid to the Contractor. Should Medicaid experience an increase in inpatient costs in an amount greater than its' anticipated trend rate of five percent (5%), the amount of the increase above the trend

rate will be subtracted from the amount withheld from the PMPM on a dollar to dollar basis, up to the total of the withheld amount. Any remaining funds are then paid to the Contractor, to be added pro-rata (2/12ths of previous period and 10/12ths of the latest period in order to align with the state fiscal year) to the Annual Benefits Expense Report, in order to determine the amount of the quality assurance withhold to be designated as Community Health Initiatives.

(AMENDMENT 3) Additionally, should the IDHW experience a five percent (5%) or greater reduction in behavioral health inpatient costs, fifty percent (50%) of the savings realized will be paid to the Contractor. The calculations will occur on an annual basis throughout the life of the contract with the comparison period being the initial inpatient fee for service expenditures (09/2012-08/2013). The incentive payment for reduction of inpatient costs is capped at five percent (5%) of the net PMPM (the proposed PMPM less the five percent (5%) withhold). The incentive payment is not subject to the fifteen percent (15%) PMPM Administrative Cost limitation shown in the tables above. Both the net and total PMPM must be certified by the IDHW's actuary as actuarially sound rates. All payments, including withhold and incentive payments, must be actuarially sound as required by 42 CFR 438.6.

### **Billing Procedure:**

The Contractor shall submit deliverables in accordance with established timelines and shall submit Encounter Claims to the IDHW's MMIS contractor. Per 42 CFR § 431.55(h) and 42 CFR § 438.808. FFP is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP.

Inquiries, invoices, and deliverables shall be submitted to:

Division of Medicaid  
Idaho Behavioral Health Program  
3232 Elder Street  
Boise, ID 83705  
Phone: (208) 364-1813  
Fax: (208) 364-1811  
E-mail: [WelshD@dhw.idaho.gov](mailto:WelshD@dhw.idaho.gov)

### ATTACHMENT 3 - DEFINITIONS AMENDMENT 3

<b>Action</b>	Action means the denial or limited authorization of a requested service; termination, suspension, or reduction of a previously authorized service, the denial in whole or in part of a payment for service; or the failure to act upon a request for services in a timely manner.
<b>(AMENDMENT 3) Administration (Administrative Costs)</b>	Includes, but is not limited to, startup costs, general operating and personnel expenses, such as salaries, profit, supplies, travel, recruiting, enrolling, and maintaining a behavioral health provider network; hiring and maintaining sufficient staff to implement, administer, and manage the Idaho Behavioral Health Plan; verifying eligibility for Members and providers; claims processing and prior authorization of services when required; maintaining and reporting claims data; monitoring claims and reporting patterns of potential overutilization, fraud, and abuse to the IDHW; providing Customer Service for Members and providers; paying providers; and participating in the IDHW's Appeal and Fair Hearing processes when required by the IDHW. For the purposes of the managed care model of service delivery all aspects of case management and care management are also included as administrative costs. Excludes quality improvement costs and fraud prevention activities as defined in the Medical Loss Ratio (MLR).
<b>Adverse Determination</b>	An admission, availability of care, continued stay, or other health care service that has been reviewed, and based upon the information provided, does not meet requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service is therefore denied, reduced, suspended, delayed, or terminated.
<b>Americans with Disabilities Act of 1990 (ADA)</b>	The Americans with Disabilities Act prohibits discrimination against people with disabilities in employment, transportation, public accommodation, communications, and governmental activities. The ADA also establishes requirements for telecommunications relay services.
<b>Appeal</b>	Appeal means a clear expression by the Member, or the Member's authorized representative, following a decision by the Contractor, that the Member wants the opportunity to present his or her case to the IDHW.
<b>Assessment</b>	A process that integrates information from various sources, including test information when available; a process for evaluating behavior, psychiatric constructs, and/or characteristics of individuals for the purpose of making decisions regarding classification, selection, placement, diagnosis, or intervention.
<b>Capitated Payment</b>	A monthly payment to the Contractor on behalf of each Member for the provision of behavioral health services under this contract. Payment is made regardless of whether the Member receives services during the month.

<b>CAFAS/PECFAS</b>	The Child and Adolescent Functional Assessment Scale® (CAFAS) is a standardized tool used for assessing a youth's day-to-day functioning across critical life subscales and for determining whether a youth's functioning improves over time. The CAFAS is for school-age children, kindergarten through the 12 <sup>th</sup> grade or ages 5 to 17 years old. The Pre-school and Early Childhood Functional Assessment Scale® (PECFAS) is for children of pre-school age, 4 to 7 years-old, or who have psychosocial delays. Idaho Medicaid uses the tool to establish eligibility criteria for rehabilitative behavioral health services. <a href="http://www.fas.outcomes.com/">http://www.fas.outcomes.com/</a>
<b>Care Management</b>	Care management is the overall system of medical and psychosocial management encompassing, but not limited to: utilization management, care coordination, discharge planning following restrictive levels of care, continuity of care, care transition, quality management, service verification.
<b>Case Management</b>	Case Management is a collaborative process of planning, facilitation, and advocacy for options and services to meet a Member's needs through communication and available resources to promote high quality, cost-effective outcomes. Qualified staff provides Case Management services to assist Members in gaining timely access to the full range of needed services.
<b>Centers for Medicare and Medicaid Services (CMS)</b>	The agency within the U.S. Department of Health and Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children's Health Insurance Program under Title XXI of the Social Security Act. This agency was formerly known as the Health Care Financing Administration (HCFA).
<b>CHIP</b>	The Children's Health Insurance Program was created in 1997 by Title XXI of the Social Security Act.
<b>Claim</b>	A request for payment for benefits received or services rendered.
<b>Clean Claim</b>	A claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.
<b>Code of Federal Regulations (CFR)</b>	The CFR is the codification of the general and permanent rules published in the Federal Register by the executive IDHWs and agencies of the Federal Government. It can be found at: <a href="http://ecfr.gpoaccess.gov/cgi/t/text/textidx?c=ecfr&amp;ndtpl=%2Findex.tpl">http://ecfr.gpoaccess.gov/cgi/t/text/textidx?c=ecfr&amp;ndtpl=%2Findex.tpl</a>
<b>Complaint (General)</b>	A General Complaint is considered to be an expression of dissatisfaction logged by a participant, a participant's authorized representative or a provider concerning the administration of the plan and services received. Actions subject to a General Complaint include, at a minimum, dissatisfaction with the benefit plan, a provider, a participant, or the way in which the Contractor or subcontractor administers the plan. The contractor has sole responsibility for resolving and tracking General Complaints.
<b>Continuum of Care</b>	A comprehensive spectrum of services organized into a coordinated and

	integrated network to meet the multiple and changing needs of emotionally and behaviorally challenged children and their families and adults. It is essential that all providers support and are connected with local community partners, including family-run organizations, youth support groups, and natural helpers such as faith-based organizations to ensure continuity of services and appropriate aftercare supports.
<b>Co-Occurring Disorders (COD)</b>	The presence of mental and addictive disorders. Members said to have COD have one or more addictive disorders as well as one or more mental disorders.
<b>Core Services</b>	The essential services necessary to provide triage level of screening, assessment, and initial treatment for behavioral health issues.
<b>Corrective Action Plan (CAP)</b>	A plan designed to ameliorate an identified deficiency and prevent recurrence of that deficiency. The CAP outlines all steps/actions and timeframes necessary to address and resolve the deficiency.
<b>CPT®</b>	Current Procedural Terminology®, current version, is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. DHHS designated the CPT code set as the national coding standard for physician and other health care professional services and procedures under HIPAA.
<b>Credentialing</b>	The Contractor's process for verifying and monitoring providers' licensure, liability insurance coverage, liability claims, criminal history and Drug Enforcement Administration (DEA) status. ID Code § 56-255 requires behavioral health agencies to be nationally accredited.
<b>Crisis</b>	A crisis is a sudden or unexpected behavior in a person that indicates the presence of acute psychiatric symptoms and the need for immediate action by a psychiatrist or members of an interdisciplinary team. Acute psychiatric symptoms include suicidal thoughts, threats or attempts; active delusions; active hallucinations; fugue states; threats of harm to self or others; violence; and sudden changes in mental status.
<b>Cultural Competence</b>	The U.S. Department of Health and Human Services, Office of Minority Health defines cultural and linguistic competence as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. "Culture" refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups. "Competence" implies having the capacity to function effectively as a participant and an organization within the context of the cultural beliefs, behaviors, and needs presented by Members and their communities. Cultural affiliations may include, but are not limited to race, preferred language, gender, disability, age, religion, deaf and hard of hearing, sexual orientation, homelessness, and geographic location. The requirements for cultural competency are described at 42 CFR §438.206(c)(2).
<b>Denied Claim</b>	A claim for which no payment is made to the network agency by the Contractor for any of several reasons, including but not limited to, the claims is for non-covered services, the agency or Member is ineligible, the claims is a duplicate of another transaction, or the claim has failed to pass a significant requirement (or edit) in the claims processing system.

<b>Department of Health and Human Services (DHHS)</b>	The U.S. government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. DHHS provides oversight for more than 300 programs, covering a wide spectrum of activities, including medical and social science research; preventing outbreaks of infectious diseases; assuring food and drug safety; over-seeing Medicaid, Medicaid, and CHIP; and providing financial assistance for low-income families.
<b>Drug Testing</b>	Drug testing involves a urinalysis to detect the presence of alcohol or drugs in the Member.
<b>Duplicate Claim</b>	A claim that is either a total or a partial duplicate of services previously paid.
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>	A federally-required Medicaid benefit for individuals under the age of 21 years that expands coverage for children and adolescents beyond adult limits to ensure availability of: 1) screening and diagnostic services to determine physical or mental defects and 2) health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered (45 CFR § 440.40(b) ). EPSDT requirements help ensure access to all medically necessary health care services within the federal definition of "medical assistance".
<b>Electronic Health Record</b>	A computer-based record containing health care information. This technology, when fully developed, meets provider needs for real-time data access and evaluation in medical care. Implementation increases the potential for more efficient care, speedier communication among agencies, and management of managed care organizations.
<b>Encounter Data</b>	Records of medically-related services rendered by an agency to a PAHP Member on a specified date of service. This data is inclusive of all services for which the PAHP has any financial liability to an agency.
<b>Enrollee</b>	As used in this RFP, an enrollee means a Medicaid Member who is enrolled in the Idaho Medicaid Management Information System (MMIS) and does not belong to an excluded population.
<b>Evidence-Based Practice</b>	The U.S. Department of Health and Human Services defines an evidence-based practice as one in which strategies supported by scientific research are identified, assessed, and implemented. Evidence-based interventions have demonstrated positive outcomes in several research studies to assist individuals in achieving their desired goals of health and wellness.
<b>Federal Financial Participation (FFP)</b>	Also known as federal match or the percentage of federal matching dollars available to a state to provide Medicaid and CHIP services. The Federal Medical Assistance Percentage (FMAP) is calculated annually based on a formula designed to provide a higher federal matching rate to states with lower per capita income.
<b>Federally Qualified Health Center (FQHC)</b>	An entity that receives a grant under Section 330 of the Public Health Service Act, as amended to provide primary health care and related diagnostic services to individuals on a sliding fee schedule. The FQHC may also provide dental, optometric, podiatry, chiropractic, and behavioral health services.

<b>Fiscal Year (FY)</b>	The term refers to the budget year. The federal fiscal year (FFY) is October 1 through September 30. The State fiscal year (SFY) is July 1 through June 30.
<b>Fraud</b>	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or State law. Fraud may include deliberate misrepresentation of need or eligibility, providing false information concerning costs or conditions to obtain reimbursement or certification, or claiming payment for services which were never delivered or received.
<b>GAIN®</b>	The Global Appraisal of Individual Needs ® is an integrated series of measures and computer applications designed to support a number of treatment practices, including initial screenings; brief interventions; referrals; standardized clinical assessments for diagnosis, placement, and treatment planning; monitoring of changes in clinical status, service utilization, and costs; and subgroup- and program-level needs assessment and evaluation. <a href="http://www.chestnut.org/Li/gain/index.html">http://www.chestnut.org/Li/gain/index.html</a>
<b>Grievance</b>	Grievance means an expression of dissatisfaction challenging the Contractors action
<b>Healthcare Effectiveness Data and Information Set (HEDIS)</b>	HEDIS is a set of performance measures developed by the National Committee for Quality Assurance (NCQA). The measures were designed to help health care purchasers understand the value of health purchases and measure plan (e.g., PAHP) performance.
<b>HIPAA</b>	Health Insurance Portability and Accountability Act
<b>ICD-9-CM ®</b>	International Classification of Diseases, Revision, 9 <sup>th</sup> Clinical Modification® identifies diagnoses. The Contractor shall move to the ICD-10-CM as it becomes effective.
<b>IDHW</b>	The Idaho Department of Health and Welfare
<b>Idaho Administrative Procedures Act (IDAPA)</b>	Idaho Administrative Code refers to the administrative rules governing the IDHW. IDHW rules are contained in IDAPA 16, and can be found at: <a href="http://adm.idaho.gov/adminrules/rules/idapa16/16index.htm">http://adm.idaho.gov/adminrules/rules/idapa16/16index.htm</a>
<b>Medicaid</b>	A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving eligible individuals.
<b>Medicaid Management Information System (MMIS)</b>	Mechanized claims processing and information retrieval system that all Medicaid programs are required to have and must be approved by the Secretary of DHHS. This system pays claims for Medicaid services and includes information on all Medicaid providers and enrollees.
<b>(AMENDMENT 3) Medical Loss Ratio (MLR)</b>	The calculation of the MLR is the sum of the Contractor's incurred claims, expenditures on activities that improve health care quality as defined in 45 CFR 158.150, and fraud prevention activities defined in 42 CFR 438.608 (limited to zero point five percent (0.5%) of contractor's revenues), divided by the premium revenue minus federal and state taxes and licensing and regulatory fees.
<b>Medicare</b>	The federal medical assistance program in the United States, authorized in 1965

	by Title XVIII of the Social Security Act, to address the medical needs of U.S. citizens 65 years of age and older and some people with disabilities under the age of 65.
<b>Member</b>	A Medicaid recipient who is subject to mandatory enrollment or is currently enrolled in the Contractor's coverage under the contract for the Idaho Behavioral Health Plan. 42 CFR § 438.10(a).
<b>Member Bill of Rights</b>	The Members' Bill of Rights is itemized at 42 CFR §438.100
<b>Network</b>	As used in this RFP, "network" is a group of participating behavioral health agencies and individual practitioners linked through contractual arrangements to the PAHP to supply a range of behavioral health care services. The term "provider network" is also used.
<b>Network Adequacy</b>	Refers to the network of behavioral health care providers for the PAHP (whether in-or out-of-network) that is sufficient in numbers and types of providers to ensure that all services are accessible to Members without unreasonable delay. Adequacy is determined by a number of factors, including, but not limited to, agency/Member ratios, geographic accessibility and travel distance, waiting times for appointments, and hours of agency operations.
<b>Notice</b>	Notice means a written statement of the action the Contractor has taken or intends to take, the reasons for the action, the Member's right to file a Grievance and request a fair hearing with the IDHW, and the procedures for exercising that right.
<b>Notice of Action</b>	Notification of the Member by the Contractor, of the action they have taken or intend to take regarding denial or limit of authorization of a requested service; termination, suspension, or reduction of a previously authorized service; the denial, in whole or in part, of a payment for service; or the failure to act upon a request for services in a timely manner.
<b>Performance Improvement Projects (PIPs)</b>	Projects to improve specific quality performance measures through ongoing measurements and interventions that result in significant improvement, sustained over time, with favorable effects on health outcomes and Member satisfaction.
<b>Performance Measures</b>	Performance measures are specific, operationally defined performance indicators that utilize data to track performance, quality of care, and to identify opportunities for improvement in care and services.
<b>Per Member Per Month (PMPM) Rate</b>	The PMPM rate paid to the Contractor for the provision of behavioral health services to enrolled Members. PMPM refers to the amount of money paid or received on a monthly basis for each enrolled Member.
<b>Post-stabilization Services</b>	In accordance with 42 CFR §438.114(a), post- stabilization services are covered services related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain, improve, or resolve the Member's stabilized condition.
<b>Practitioner</b>	As used in this RFP, an individual who is qualified to provide behavioral health services within the scope of his or her practice and licensure and/or certification and in accordance with state and federal regulations.

<b>Prepaid Ambulatory Health Plan (PAHP)</b>	In accordance with 42 CFR § 438.2, a PAHP is an entity that: Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and Does not have a comprehensive risk contract.
<b>Primary Care Services</b>	Health care and laboratory services customarily furnished by, or through, a primary care provider (PCP) for diagnosis and treatment of acute and chronic illnesses, disease prevention and screening, health maintenance, and health promotion, either by the PCP or through appropriate referral to specialists and/or ancillary providers.
<b>Primary Care Provider (PCP)</b>	An individual physician, licensed nurse practitioner, or licensed practitioner of the healing arts (a licensed physician, physician assistant, nurse practitioner, or clinical nurse specialist; the nurse practitioner and clinical nurse specialist must have experience prescribing medications for psychiatric disorders) responsible for the management of a Member's health care, who is licensed and certified in one of the following general specialties: family practice, pediatrics, internal medicine and pediatrics, or obstetrics/gynecology. The PCP is the Member's point of access for preventive care or an illness and may treat the Member directly, refer the Member to a specialist (secondary/tertiary care), or admit the Member to a hospital.
<b>Professional Standards/ Industry Standards</b>	The generally accepted requirements followed by the members of an industry and the ethical or legal duty of a professional to exercise the level of care, diligence, and skill prescribed in the code of practice of his or her profession, or as other professionals in the same discipline would in the same or similar circumstances.
<b>Protected Health Information (PHI)</b>	Individually-identifiable health information that is maintained or transmitted in any form or medium and for which conditions for disclosure are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 CFR §160 and 164.
<b>Quality</b>	As it pertains to the independent assessor's quality review, the degree to which the Contractor increases the likelihood of desired health outcomes of its Members through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.
<b>Quality Management (QM)</b>	The ongoing process of assuring that the delivery of covered services is appropriate, timely, accessible, available, medically necessary, in keeping with established guidelines and standards, and reflective of the current state of medical and behavioral health knowledge.
<b>Readiness Review</b>	This term refers to the two (2) phase process where the IDHW assesses the Contractor's ability to fulfill the requirements of the Contract through confirmation of the work described in the Attachment 9 – Initial Deliverables and Attachment 10 – Readiness Review. Such review may include, but is not limited to, review of proper licensure, operational protocols, Contractor standards, and systems.

	The review may be completed as a desk review, on-site review, or combination of the two, and may include interviews with pertinent personnel so that the IDHW can make an informed assessment of the Contractor's ability and readiness to render services.
<b>SAMHSA</b>	Substance Abuse and Mental Health Services Administration
<b>Screening</b>	Screening is a systematic examination or assessment, using a standardized tool, to determine the existence of certain physical or mental illnesses or conditions or addiction disorders.
<b>Second Opinion</b>	Subsequent to an initial medical opinion, a second opinion is an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally recommending a proposed health service, to assess the clinical necessity and appropriateness of the initial proposed health service.
<b>Serious Mental Illness (SMI)</b>	<p>In accordance with 42 CFR § 483.102(b)(1), a person with SMI:</p> <p>Currently or at any time during the year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified in the DSM-IV-TR; and</p> <p>Has a functional impairment that substantially interferes with or limits one (1) or more major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning with an individual's basic daily living skills, instrumental living skills, and functioning in social, family, vocational or educational contexts. Instrumental living skills include maintaining a household, managing money, getting around the community, and taking prescribed medication.</p> <p>An adult who met the functional impairment criteria during the past year without the benefit of treatment or other support services is considered to have a serious mental illness.</p>
<b>Serious and Persistent Mental Illness (SPMI)</b>	<p>In order to be considered as having a SPMI, a Member must have a medically documented history, over a period of at least 1 year, of the existence of a serious and persistent mental disorder. The diagnosis must meet the following criteria:</p> <p>The evidence shows that continuing treatment, psychosocial support(s), or a highly structured setting diminishes the symptoms and signs of the mental disorder.</p> <p>The evidence shows that the Member has achieved only marginal adjustment despite their diminished symptoms and signs. "Marginal adjustment" means that that the Member's adaptation to the requirements of daily living and their environment is fragile; that is, they have minimal capacity to adapt to changes in their environment or to demands that are not already part of their daily life. Changes or increased demands would likely lead to an exacerbation of their symptoms and signs and to deterioration in their functioning; for example, they would be unable to function outside a highly structured setting or outside their home.</p> <p>Similarly, because of the nature of their mental disorder, they could experience episodes of deterioration that require them to be hospitalized or absent from work, making it difficult for them to sustain work activity over time.</p> <p>Definition taken from: Federal Register/Vol. 75, No. 160/Thursday, August 19, 2010/Proposed rules</p>
<b>Serious Emotional Disturbance (SED)</b>	An emotional or behavioral disorder, or a neuropsychiatric condition which results in a serious disability, and which requires sustained treatment interventions, and

	causes the child's functioning to be impaired in thought, perception, affect or behavior. A disorder shall be considered to "result in a serious disability" if it causes substantial impairment of functioning in family, school or community. A substance abuse disorder does not constitute, by itself, a serious emotional disturbance, although it may coexist with serious emotional disturbance. ID Code § 16-2403.
<b>Service Authorization</b>	The review and consistent authorization or denial of a request by the Member, or the Member's authorized representative, for a service covered under this contract to be provided. 42 CFR § 438.210
<b>Stakeholder</b>	A person, group, or organization that has a direct or indirect investment, share, or interest in an organization, project, or system because it can affect or be affected by the actions, objectives, and policies of the organization, project, or system. Stakeholders include, but are not limited to, rule makers, the State Legislature, professional associations, providers of services, payers of services, funding sources, regulators, Members, and the families of Members.
<b>Substance Use Disorder (including Substance Dependence and Substance-related Disorder)</b>	<p>Substance Use Disorder includes substance dependence and substance abuse, according to the DSM-IV-TR. Substance use disorders are one(1) of two (2) subgroups of the broader diagnostic category of substance-related disorders;</p> <p>Substance Dependence: Marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use alcohol or other drugs despite significant related problems. The cluster of symptoms can include: tolerance, withdrawal or use of a substance in larger amounts or over a longer period of time than intended, persistent desire or unsuccessful efforts to cut down or control substance use, a great deal of time spent in activities related to obtaining or using substances or to recover from their effects, relinquishing important social, occupational or recreational activities because of substance use, and continuing alcohol or drug use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by such use as defined in the DSM-IV-TR.</p> <p>Substance-related Disorders: Include disorders related to the taking of alcohol or another drug of abuse, to the side effects of a medication and to toxin exposures. They are divided into two (2) groups: the Substance Use Disorders and the Substance-Induced Disorders as defined in the DSM-IV-TR.</p>
<b>System Defect</b>	A system defect is an identified error with the system where the system is not operating according to the approved design or requirements. System defects are not the same as other issues related to human error, or training. They are errors introduced by a component of the system.
<b>Urgent Behavioral Health Care</b>	For the purposes of this RFP care that is necessary due to a behavioral health condition that, after applying the prevailing behavioral health standards of judgment and practice within the community, would require immediate behavioral health intervention because of the Member's acute symptoms that have the potential to become an emergency health condition that would place the health or safety of the Member, or someone else, in serious jeopardy in the absence of behavioral health treatment for the Member. Conditions needing urgent behavioral health care include, but are not limited to, significant emotional

	distress, suspected or obvious psychotic break, or mental trauma.
<b>Utilization Management</b>	<p>The process of managing costs and use of services through effective planning and decision-making to assure that services provided are appropriate and cost-effective; it is composed of the following elements:</p> <ul style="list-style-type: none"> <li>deciding who will be served</li> <li>assessing service needs and identifying desired outcomes</li> <li>deciding what services to provide</li> <li>selecting service providers and determining costs</li> <li>implementing, monitoring, changing and terminating services</li> </ul>
<b>Utilization Review</b>	<p>An element of utilization management, it is the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, facilities, and practitioners under the provisions of the applicable health benefits plan. It involves a set of techniques used by or on behalf of purchasers of health care benefits to manage the cost of health care before its provision by influencing patient-care decision making through case-by-case assessments of the appropriateness of care based on professional and industry standards. Utilization review is done at the individual Member level as well as a system level.</p>